IN THE COURT OF COMMON PLEAS

STARK COUNTY, OHIO

CASE NO. 1997 CV 01587

DELLA M. SHANOWER, et al., Plaintiffs, versus CHARLES F. HOLCOMB, et al., Defendants.

VIDEO DEPOSITION OF ALEJANDRO SOS, M.D.

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Deposition of ALEJANDRO SOS, M.D., a Witness herein, called by the Plaintiffs for Direct Examination pursuant to the Ohio Rules of Civil Procedure, taken by the undersigned, Linda McAnallen, a Stenographic Reporter and Notary Public in and for the State of Ohio, at the offices Alejandro Sos, M.D., 1445 Harrison Avenue, N.W., Canton, Ohio, on January 8, 1998. at 2:10 p.m.

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APPEARANCES:

On Behalf of the Plaintiffs:

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ALSO PRESENT:

Mike Cuerrieri, State Farm

Dave Burris, Video Reporter
Mirror Image Video & Pllotogrophy

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OBJECTIONS & MOTIONS

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WHEREUPON,
ALEJANDRO SOS, M.D.,
after being first duly sworn, as hereinafter certified, testified as follows:
DIRECT EXAMINATION
BY MR. SOLES:
Q. Good afternoon, Dr. Sos. My name is Bob Soles, and I represent the plaintiffs in this case, Della Shanower and Corlin Shanower. We're here to take your video deposition. For the benefit of the jury, I understand that you have a busy schedule and are unable to testify live. Is that correct?
A. That's correct.
Q. Do you understand that your testimony will be played back before the jury?
A. Yes, I do.
Q. Doctor, if you'd please keep your voice up. I'd first like to ask you for your full name.
A. Alejandro Sos.
Q. And your professional address, sir?
A. 1445 Harrison Avenue, Northwest, Canton.
Q. And your profession?
A. Physician.
Q. Are you licensed to practice medicine in the State

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of Ohio?
A. Yes, sir.
Q. And when did you first become licensed in Ohio to practice medicine?
A. 1980.
Q. And since then, have you been continuously licensed to practice?
A. Yes.
Q. Please tell the jury briefly about your educational background beginning with college and bring us up to date with your training in medicine.
A. Sure. I went to medical school after I finished high school studies in Madrid, Spain. I was born in Spain. I came to the United States in 1968. I did one year of internship at Unity Hospital, Brooklyn, New York. Then I moved to Washington, D.C., where I was in Georgetown University, six months neurology. Then I went to the University of Louisville in Kentucky where I did a compulsory year of general surgery in order to be able to enter a neurosurgical program. When I finished the year of general surgery at the University of Louisville, I moved to Cincinnati, the University of Cincinnati, in neurosurgery and I finished in

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1974.
Q. How many additional years did you spend learning about the specialty of neurology and neurological surgery?
A. Five years in neurology and neurosurgery -- no, excuse me, scratch, neurosurgery.
Q. And can you please explain specifically what the specialty of neurosurgery involves?
A. It is the treatment of conditions involving the central nervous system. That means the brain, the spinal cord, and the peripheral nervous system, the nerves, that could be treated or potentially treated through operations.
Q. And how long have you been engaged in the specialty of neurological surgery?
A. Since 1974.
Q. 1974?
A. Yes.
Q. Doctor, have you helped in teaching residents, medical residents, or medical students about your specialty in neurological surgery?
A. Until last year in NEOUCOM.
Q. NEOUCOM?
A. Yes.
Q. That's the Northeastern Ohio --

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A. Northeastern Ohio Universities College of Medicine.
Q. Doctor, do you have privileges at any of the local hospitals?
A. I currently have active privileges at Mercy Hospital. I have courtesy privileges at Massillon.
Q. Have you published any books or other literature dealing with your specialty of neurological surgery?
A. No books. I have three papers, one about a procedure for a tumor, melanotic schwannoma. I have another one about a very unusual tumor, arachnoidal melanocytoma. And I have another one about fibrous dysplasia of the bone.
Q. Thank you. I'd like to hand you what has been marked as Plaintiff's Exhibit 24, which I believe is your curriculum vitae or your resume. Could you please tell us if that is your current resume.
A. I forgot one, "Urgano Phosphate Insecticides". I forgot that paper. Yes. Maybe we should, too, add that I am a member of the Board of Trustees of the LifeBanc.
Q. LifeBanc?

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A. LifeBanc. I'm on the Board of Trustees. I don't think it's here reflected, but just for the record.
Q. And your resume would reflect your accomplishments in terms of publications as well as honors you received?
A. My humble accomplishments.
Q. Thank you. Now, before we discuss Mrs. Shanower's medical condition, could you help us generally understand what specifically is in a person's neck and back? What's under their skin? And if necessary, you can use the models that you have there.
A. Basically the cervical spine has 7 vertebrae, and the relationship between each one of those vertebrae is through a joint. At that joint it is called a disc. Then in this model, maybe in this model here it would be more easy for you to focus. This is a model of the cervical spine. We have 7 vertebrae, 1, 2, 3, 4, 5, 6, 7. In between each vertebra this brown area represents a disc. And this is basically the cervical spine. Of course, inside the cervical spine goes the spinal cord. And this metallic rod may represent very well the spinal cord. And from the spinal

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cord at each level between every two vertebrae there is a nerve on the left, there is a nerve on this side, and those are the cervical nerves that are going to supply most of the muscular activity of the upper extremities, neck, et cetera.
Q. So in addition to the cervical vertebrae, and you indicated there are 7 of those, what are below the cervical vertebrae, any other vertebrae?
A. Yes, 12 thoracic, 5 lumbar, 5 sacral, and 4 or 5 coccygeal.
Q. You talked a little bit about the spinal cord that is surrounded by the vertebrae. What purpose does the spinal cord serve?
A. The spinal cord carries impulses from the periphery to the brain'and from tlie brain toward the periphery and also interacts in the functioning of the vegetative system.
Here we have a section of the cervical spine, the area or section of the neck. We can see the vertebrae, the spinal cord in the center, and the nerve roots with a motor component for movement, a sensory component, that carries impulses from the periphery and the information. Here is tlie disc. We have also a vertebral artery to each side and veins.

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Q. You've mentioned the term discs. I guess I'd refer you back to the model you originally had shown. The brown material between the vertebrae are the discs?
A. The discs that represents joints between the vertebrae.
Q. And what do these discs do?
A. The discs help in the cushioning of the bones and also allow some laxity or some movement in flexion and extension of the neck or in rotation of the neck too.
Q. Okay. Thank you, Doctor. Now, are you referred patients by other physicians to help treat these patients for their neck and back injuries?
A. Yes, most of the time they are referrals by other physicians.
Q. The majority of your practice is referrals from other physicians?
A. Yes, or emergency room patients.
Q. Doctor, was Mrs. Shanower referred to you?
A. Yes.
Q. And by whom?
A. Dr. Galang.
Q. Dr. Galang was her family physician?
A. Dr. Galang was her family physician. He has

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offices in Louisville, Ohio.
Q. I'd like to direct your attention now to Della Shanower. And I know that you have her chart nearby.
A. Yes.
Q. I'd like you to feel free to refer to that to refresh your memory. Did you treat Della Shanower following her July 9, 1996, automobile crash?
A. Yes.
Q. Now, I'd like to set a few ground rules before we get into her injuries.
A. Let me explain. Not immediately after the crash. I treated her a year later.
Q. Subsequently?
A. Yes, subsequently.
Q. I'm going to ask you a number of questions regarding your diagnosis, treatment, and her prognosis, and I'm going to ask you for certain opinions, Okay?
A. Yes, sir.
Q. You have testified before, have you not?
A. Yes, sir.
Q. Are you aware that the law requires that all of your medical opinions be based on a reasonable

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degree of medical probability or certainty?
A. Yes.
Q. Now, Doctor, I want you to understand that whenever I ask you a question that calls for your medical judgment and opinion that you are to base your opinion in every instance upon a reasonable degree of medical probability and certainty. And by that I mean I don't want you to speak in terms of possibilities or speculate. Okay?
A. Yes.
Q. Now, will you agree to base all your opinions today on a reasonable degree of medical probability and certainty?
A. Yes, I will.
Q. When did you first see Della Shanower?
A. Mrs. Shanower was first seen in my office on September 23, 1997.
Q. Prior to your testimony today, did you have an opportunity to review all of Mrs. Shanower's prior medical records froin July 9, 1996?
A. I reviewed them a few minutes ago, yes, before we had this meeting.
Q. I'm going to hand you a group of exhibits that have been marked Plaintiff's Exhibits I believe

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1 through 16 or 17 there, Doctor.
A. Yes, sir.
Q. And I'd like you to go through those medical records, if you will, and identify those for us starting with Exhibit 1.
A. Exhibit 1 is a copy -- all of them are copies -- of an EMS or emergency service report.
Q. That's the Stark County EMS run report?
A. Yes.
Q. From July 9, 1996?
A. It's from July 9, 1996, yes, correct.
Q. How about Plaintiff's Exhibit 2?
A. This is a registration of Mrs. Shanower being admitted to at the time Columbia Mercy Hospital on 7-9-96.
Q. Then there are the subsequent records attached there for the emergency room; correct?
A. Yes, emergency room. She was examined by a physician, was medicated with Flexeril, and --
Q. Okay. Plaintiff's Exhibit 3, are those the records of Dr. Lamberto T. Galang?
A. Yes, this appears to be copies of Dr. Galang's office notes, inost of them handwritten, some of them typed. There is also a copy of my operative report.

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Q. Now, Plaintiff's Exhibit 4, are those the Louisville Physical Therapy Sports Rehab Center treatment notes?
A. Yes, and a prescription to have physical therapy by Dr. Galang.
Q. Plaintiff's Exhibit 6, can you identify that, Doctor?
A. Exhibit 6 is Progressive Sports & Orthopaedics, Inc., physical therapy evaluation, discharge evaluation.
Q. Oh, I'm sorry, Plaintiff's Exhibit 6, Doctor.
A. Oh, 6?
Q. Yes. Is that the CT of the cervical spine?
A. CT of the cervical spine, correct. It's a copy of the radiology report of a CT of the cervical spine, two pages.
Q. How about Plaintiff's Exhibit 7?
A. Exhibit 7 is my discharge summary on 10-8-97, orders froin the same admission and postoperative orders included.
Q. Are these the medical records from Columbia Mercy Hospital when Mrs. Shanower was admitted for surgery?
A. I think they correspond to the records when she was in the hospital for surgery.

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Q. And finally, Plaintiff's Exhibit 8, can you identify what that group of documents are?
A. Exhibit 8?
Q. 8.
A. Exhibit 8 is my initial letter addressed to Dr. Galang when I saw the patient in the office with my impression. There are also copies of my office records with follow-up of the patient on October 9, October 10, and 10/10, follow-up or phone calls by the patient, more copies of my records in the office, copies of the discharge summary froin the hospital after surgery, copy of surgery, and copy of the history and physical of that admission, and there are four copies of prescriptions.
Q. I'll be asking you a few questions about those medical records, but first I'd like you to discuss your physical examination of Mrs. Shanower.
In Mrs. Shanower's first visit with you on September 23, 1997, did you take a history of her injuries and complaints?
A. Yes, I did.
Q. Could you please explain to us and the jury what history you received froin Mrs. Shanower?
A. Yes. Well. basically the patient informed ine that

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she had been in pain, neck pain, since 1996, since July of 1996. She explained to me that she had been involved in a motor vehicle accident, that she was hit in the rear of the car, that because of the pain she went to see Dr. Galang, that Dr. Galang treated conservatively and recommended physical therapy, that she had several weeks with physical therapy treatment, that as far as she explained to me she did not improve. Then she went to Florida, because she goes every year in the wintertime, winter months to Florida. And when she returned in 1997 back to her home in Louisville, because she continued having neck pain, she went to see Dr. Galang. Dr. Galang proceeded in the same way, conservative approach, and referred her again to physical therapy. And it is the second time in the course of the physical therapy treatments when the pain intensified and the therapist asked the patient to go back to see Dr. Galang because the neck pain was worse. Then Dr. Galang ordered a CT scan of the cervical spine, and after seeing the results of the scan referred the patient to me.

Q. After he saw the result of the CT scan, she was referred to you?

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A. Yes.

Q. Now I'd like to direct your attention to the neurological examination of Mrs. Shanower. Did you conduct an examination of her after you heard her describe the pain and problems she had experienced since the crash?

A. Yes.

Q. Could you please tell the jury what you did and specifically what you found?

A. Well, I did a neurological examination that consists basically of testing a few reflexes in the upper extremities to test for strength and to test for changes in sensation, perception of sensation.

The patient had a bilateral Tinel sign. That means when we hit with a hammer in this case at the level of the wrist, she had an electric shock-like sensation. But that then and now is not related to the accident. It is not related, that finding, but it was a finding in the examination. It was compatible with having a bilateral carpal tunnel syndrome. I explained to the patient that this was not related to the accident.

Her hand grip was decreased as compared

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with what it used to be. The deep tendon reflexes were decreased in both upper extremities.

Q. What do you mean when you say deep tendon reflexes were decreased?

A. Deep tendon reflexes means that when we strike with a rubber percussion hammer on the --

Q. Is this --

A. Yes, this is a percussion hammer. When we strike on certain areas where the tendons are inserting into the --

Q. Where on Mrs. Shanower would you strike that she would have these deep tendon reflexes?

A. And the deep tendon reflexes were weaker than I would expect.

Q. I mean would it be on her elbow or where would it have been that you would have --

A. Well, we checked biceps, triceps, and brachioradialis. That means the flexor of the elbow, on the back of the ann, and here, too.

Q. And that demonstrated deep tendon reflexes were decreased?

A. Yes, they were down.

Q. Go on. I'msorry.

A. And then also she had what I labeled in my dictation questionable liypoesthesia on the C6

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territory of the left upper extremity. And for the benefit jury, I will explain. There is sort of a map like that is the same for every human being, and certain areas of the upper extremity provide innervation by certain nerves and only by those nerves in every human being.

Then when I say that the C6 territory was with some hypoestliesia, it means that the sensation appeared to be decreased when I hit the patient with a pinwheel or with a safety pin. And the C6 territory involves the thumb and the index finger and all this down on the forearm. The next would be C7, the next would be C8.

Then by knowing what is the pattern of innervation, we can infer either nerve which is the origin of that innervation is involved, affected, or restricted in function for anything.

But anyway, she had decreased tendon reflexes, she had hypoesthesia on the C6 territory that I qualified as questionable because her answers were not crystal clear, and the hand grip was decreased, too.

Q. Did these findings lead you to believe what was wrong with Mrs. Shanower, that there were some problems with the C6?

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A. These findings indicate that possibly it could be something at the C6 level, something -- not the C6 level, something involving the C6 nerve. C means cervical, the cervical nerve number 6. And the cervical nerve number 6 is exiting the spine between the vertebrae 5 and 6. 1, 2, 3, 4, 5, 6. And the nerve which is coming here is nerve number 6, between 5 and 6. That will fit or would fit with the findings of the CT scan.

Q. You previously testified that after reviewing the CT scan that was taken of her on September 8, 1997, Dr. Galang referred Mrs. Shanower to you.

A. Yes.

Q. Did you also review that CT scan of Mrs. Shanower's cervical area?

A. Yes, she brought the films to the office. And also to better recall, I saw again the films last night.

Q. Could you help us understand what a CT scan is or how it is done?

A. A CT scan is a different type of x-ray, that all the information obtained through the x-ray machine goes to a computer room, and the computer performs most of the time an axial reconstruction. That means like if we make a section parallel to the

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floor where tlie patient is standing up, this is an axial view. Then we can see the spine from the periphery toward the center more or less as we can see over there.

Q. In your review of the medical records for Mrs. Shanower from the time of the crash on July 9, 1996, to tlie date that the CT scan was taken on September 8, 1997, did you see that there were any other x-rays, MRIS, or CT scans taken of her cervical area?

A. No, there were none taken as far as I know.

Q. Tell us what tlie CT scan demonstrated.

A. The CT scan demonstrated a large disc herniation. That means tlie joint that we call disc that contains has ruptured, come out of place into the spinal canal on tlie left side, compressing or pushing against tlie nerve root, the C6 nerve root at that level.

Q. You also indicated that there was compression of the thecal sac and spinal cord centrally.

A. Yes.

Q. Can you please explain what you mean by that or what the report meant by that?

A. I have here a model. What happened is -- it is very simple. If this is the disc, in red is the

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disc herniated, in blue is the rest of tlie disc that has not herniated. Obviously when it comes out, it's going to be pushed against the nerve root, but also it's going to be pushing against the spinal cord.

The spinal cord is covered by a membrane that is called dura, d-u-r-a, which means hard, and we call also thecal, t-h-e-c-a-1, thecal sac. It is like a finger glove surrounding the spinal cord. Then if the disc is herniated, it's going to push the thecal sac, that means dura, then it's pushing the spinal cord, and also it's going to be pushing against the nerve.

Q. Did you consider this to reflect a serious injury or serious medical condition?

A. At the time I saw her I recommended surgery right away, because if the disc material would have herniated further, further herniation, it could cause paralysis because of compression on tlie spinal cord.

Q. Would this have been a painful condition?

A. It would be catastrophic. She will be paralyzed.

Q. After your diagnosis of the herniated disc in reviewing the CT scan at C5-6, what did you recommend to Mrs. Shanower?

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A. I recommended and I wrote in my letter to Dr. Galang, and I quote, "The patient should proceed as soon as possible with an anterior cervical discectomy at C5-C6 with foraminotomies and fusion."

The reason was because again if that disc material that was already large will increase in size, it could compress the spinal cord with irreversible or at least very serious damage. Then my recommendation was surgical.

Q. And that that be imminently performed or in a quick time period?

A. Yes. As a matter of fact, I saw her on the 23rd, and I don't remember now when I operated her, but I do remember very well.

Q. Did she in fact undergo surgery?

A. Yes, she had surgery.

Q. And does October 6, 1997, sound like the date that she may have undergone the surgery?

A. Yes, 10-6-97.

Q. And was that at Columbia Mercy or Mercy Medical Center?

A. Yes. So I decided less than two weeks later.

Q. Could you please explain to us and tlie jury in detail how the surgery was performed?

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A. Well, the patient is under general anesthesia, supine, that means face up on the table. The neck is moderately hyperextended with some bag under the nape of the neck. The patient is horizontal then. We place with tape a metallic marker on the side of neck to approximately see what is the level of the vertebrae or vertebra we are going to be intervening. Then at that level we trace a small mark on the neck with a scalpel. I use always a scalpel. Then the area is painted with betadine, infiltrated with a local anesthesic with epinephrine in order to decrease the bleeding of the skin when we cut.

Q. Could you show on your neck where you would have cut open Mrs. Shanower?

A. Yes, following always one of the skin curves. We paint the neck for ten minutes with Betadine. We put drapes. They are sutured to the skin. The incision made. Then after we make the incision, we cut the first layer of muscle, the platysma. And after that we see the sternocleidomastoid muscle, it is this muscle here. We retract it. And just by blunt dissection without cutting the muscles, leaving the track here and the esophagus medial and the carotid artery and the jugular vein

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lateral with the fingers and scissors, we reach the anterior aspect of the cervical spine.

Once we are there, we put a spinal needle as a marker on the anterior aspect of the spine through one of these spaces that most of the time is going to be the one that we want to intervene. We do a lateral x-ray of the neck. Once we get the lateral x-ray of the neck, if we are in the right space, we have to remove the disc. We use magnification. We use loops. I use always loops. Some people use a microscope, but I don't think it is necessary.

Q. What are loops?

A. Magnifying glasses, three-and-a-half. And whether this is removed -- we put a vertebral spreader to distract, to separate a little bit the vertebral bodies like that. Then we can see inside, and we can see if there is still material or a piece of bone pushing against the nerve. And we cut it off, we remove, until everything is clean.

Once everything is clean, following the technique that I used that is called the Cloward technique -- it's a well-known techique. For more than thirty years this technique has been used We drill a cylindrical defect between the vertebra

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above and the vertebra below, and through that defect we may clean still more material. And after that, we put a bone graft like this here between the two vertebrae to fuse.

Q. In reviewing your operative notes, what did you find when you went into the cervical spine?

A. I found a very large disc that had ruptured the posterior ligament and was compressing against the dural sac or thecal sac that covers the spine and it was also pushing against the C6 nerve root on the left side.

Q. In your operative note you indicate, "Once this was done with angled curet, I proceeded to remove further disc material that was completely herniated even beyond the ligament and into the canal." That would be the spinal canal; correct?

A. Yes.

Q. "Since the disc material has been herniated probably for quite some time, it had multiple adhesions and adherences to the ligament." Could you explain that, Doctor?

A. Well, to my understanding it is because probably the disc herniation I believe, honestly believe, had been there for quite some time. Then over the ensuing months, that material had developed some

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adhesions with the ligament and with the structures around. It was a little bit more laborious to remove, but anyway we removed it, no problem.

Q. Now, you mentioned that you had to get a bone fragment I guess from the bone bank?

A. Yes.

Q. And for what purpose did you do that?

A. A bone graft, it's the thing that I mentioned here, to fuse the interspace. These are commercially available. They come in different sizes and the only thing we trim is the length.

Q. So this was for purposes of fusing the two vertebrae together?

A. Fusing the two vertebrae together to have a stable spine.

Q. How long does a surgery like this usually take?

A. One level, around two hours.

Q. How did Mrs. Shanower tolerate this surgery?

A. She did well,

Q. Do you know when she was released from the hospital?

A. Yes, she was released two days later, 10-8.

Q. On October 8th?

A. But this is not because I am very good. This is

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because the insurance force us to release the patients right away. No, but she was released okay. She did well.

MR. SOLES: I'll object to that, but --

THE WITNESS: Want to scratch it? Scratch it.

Q. Was she given any prescriptions?
A. Yes, she was given Darvocet for pain.
Q. How about any anti-inflammatories?
A. No, only Darvocet. And let me see my discharge note. It must be here. Restricted activities, Darvocet, and return to tlie hospital as an outpatient in a week to remove the sutures.
Q. You also gave her a soft cervical collar?
A. Yes.
Q. And for what purpose would she have liad a soft cervical collar?
A. The soft cervical collar we put on tlie patient in tlie operating room even before slie wakes up. It is put on on the table. It is to prevent excessive motion of the neck, maybe to remind the patient constantly that she should be careful or he should be careful about activities with the neck, plus also to help to relieve some of the

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pressure. The head is very heavy, and when the collar is holding the head against the shoulders, then the neck is not so compressed and the bone graft does not collapse. Occasionally one of those bone grafts may collapse, especially if the cancellous bone is old bone, is deteriorated, is not too healthy, it may collapse just from tlie pressure of the head. And we use the collar to prevent all these problems.
Q. For how long would she have been required to wear it?
A. Six weeks.
Q. I also noted a prescription for an electrical hospital bed?
A. Yes.
Q. For what reason would slie have that?
A. Well, she liad difficulties getting in and out of tlie bed at her house. And I don't know the family situation, but slie called and asked if it was fair, and I think I approved a hospital bed for four weeks.
Q. Now, after surgery did you restrict her activities or were lier activities restricted in any manner?
A. Yes, all these patients are reminded that they

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should be at home the first four weeks without going anywhere to prevent a fall, an accidental injury, or somebody push them on the street. And also they are not allowed or at least I ask them do not ride, do not drive in the car, because if the car would be involved in just a fender-bender injury, the neck could be with problems.
Q. You indicated that I guess she saw you a week later to have her stitches removed?
A. Yes.
Q. And where would that have been?
A. It was in the hospital.
Q. At the hospital?
A. A minor outpatient surgery, yes, about ten minutes.
Q. In reviewing your office notes, I think you testified before that she called your office several times after surgery.
A. Yes.
Q. I'd like to ask you a couple questions about that. For example, on October 9th she coniplained about a funny feeling down the top of her left shoulder radiating down her left arm, and she also complained that while holding a straw with her

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right arm that when she swallows, her hand would jerk. Two others. On October 17th she complained of her shoulder throbbing and neck pain and requested another prescription for anti-inflammatories. And then finally on October 27, 1997, she called and complained of having trouble with her shoulder throbbing and that as long as she took the anti-inflammatories she didn't have problems, but then when the anti-inflammatories wore off, tlie throbbing came back. Were these normal complaints following this type of surgery?
A. Yes. Some patients don't complain at all and some patients complain a little bit more. They have to have some discomfort in tlie neck, because the architecture of the neck through surgery lias changed a little bit. And for that reason they may have also pain in tlie neck from muscle contracture, you know. Also surgery is always an aggressive procedure.

The neck pain that slie had and pain in the shoulder could be because of changes in the position when slie sleeps, because of the recent surgery, she lias to have a collar, the neck is maintained very stiff. Then all these complaints

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eventually fade away. But she had some complaints and she called several times.
Q. There was some indication that there was a prescription for some other medication, maybe some anti-inflammatories. Do you know if there were some further prescriptions?
A. I have here the prescriptions that --
Q. Naprosyn?
A. I ordered Naprosyn, one tablet every eight hours for three days, then decrease, et cetera, etcetera.
Q. What is Naprosyn and what does it do?
A. It's a nonsteroidal anti-inflammatory. It's stronger than Motrin. It's all the same kind.
Q. What would be the purpose of taking an anti-inflammatory?
A. Well, because of the removal of the disc as well as the intervention on the spine, there has to be an inflammatory response by the tissues, yes, always after every surgery. Then if the inflammation is such that it's causing problems and the nerve is swollen or the muscles are aching because they have been displaced or transected, the anti-inflammatory would provide some comfort. It won't cure it, but it would

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provide comfort.
Q. I understand. When is the last time that you saw Mrs. Shanower?
A. Let me look in my records, please. Okay. On October the 2nd, 1997 --
Q. Would that be December? I'm sorry, Doctor. December 2nd?
A. December, excuse me. I said October. December the 2nd, 1997, there is a letter addressed to Dr. Galang. I informed him that Mrs. Shanower has been seen in my office, that she was fully recovered from surgery, and that she was discharged from my care.
Q. So at that time she was released froin your care?
A. Yes, sir, December the 2nd, 1997.
Q. Doctor, I'm going to direct you now to Plaintiff's Exhibits 9 through 16, which I'll hand you in a minute. I'm going to ask the video person to go off the record. And while we're off the record, I'd like you to look at these medical bills, and then I have a few questions for you when we get back on.
(Discussion was had off the record.)
BY MR. SOLES:
Q. Doctor, have you had an opportunity to review

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Plaintiff's Exhibits 9 through 16, which are the medical bills that Della Shanower has incurred since the date of her automobile wreck on July 9, 1996?
A. Yes.
Q. Do you have an opinion as to whether Exhibits 9 through 16 -- actually it would be Exhibits 10 through 16. Exhibit 9 is a summary.
Do you have an opinion as to whether Exhibits 10 through 16 were necessary and appropriate for the care and treatment of Della Shanower's injury following her July 9, 1996, crash?
A, Yes.
Q, What is that opinion, Doctor?
A. It seems to me they were necessary.
Q. These were reasonable?
A. Reasonable and necessary.
Q. I'll refer you to Plaintiff's Exhibit 5, Doctor. I guess earlier when we were going through the medical records, I did not ask you to identify that particular group of medical records. Could you please just identify those for purposes of the record, Doctor?
A. Yes, sir. These are photocopies of Progressive

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Sports & Orthopaedics, Inc. with an address here in Canton, Ohio. It is a physical therapy discharge evaluation dated 9-17-97 on Della Shanower.
Q. And the subsequent records to that?
A. The following is a photocopy of a handwritten note by a physical therapist addressed to Dr. Galang.
Q. You don't have to read it, Doctor. I was just asking you to identify that at this point.
A. Okay. Another Progressive Sports & Orthopaedics, Inc., physical therapy initial evaluation. That means we have the initial evaluation, the discharge evaluation, and a letter to Dr. Galang.
Q. Those are the medical records for Progressive Sports & Orthopaedics?
A. Yes, sir.
Q. Now, Doctor, I'd like to ask you for some of your opinions that you hold in this case. And again I would ask that you please give all of your opinions to a reasonable degree of medical probability and certainty. Okay?
A. Uh-huh.
Q. First with regard to causation, do you have an opinion as to whether the auto crash of July 9,

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1996, caused any injury to Della Shanower?
A. Yes.
Q. And could you please tell the jury what that opinion is, Doctor?
A. I think that the automobile accident that took place in 1996 is responsible for the disc herniation that I diagnosed and operated in 1997.
Q. And again your opinion is to a reasonable degree of medical probability and certainty?
A. Yes. It is based on a series of facts.
Q. Doctor, can you tell us whether Mrs. Shanower had any physical disability or impairment following the July 9, 1996, crash up and to December 2, 1997, when she was released from your care?
A. As far as I know, she has been with pain all this time, and probably that pain has to restrict her daily living activities to a certain extent. I don't know, I am not aware if she was or was not working, but the neck pain was constant.
Q. So it would be your opinion that this disability or impairment would have restricted say household activities, leisure, or recreational activities?
A. Yes, even driving too.
Q. Do you have an opinion whether or not Mrs. Shanower may suffer from a permanent

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condition or impairment as a result of the July 9, 1996, auto crash --
A. Yes.
Q. -- such as arthritis in her neck region?
A. Yes.
Q. And what is that opinion, Doctor?
A. At the current time I don't think she has any permanent deficits. Now, in the future she may or may not develop arthritis. Most of these patients develop arthritis in the joint above the fusion and in the joint or the disc below the fusion.
Q. So --
MR. HANRATTY: Motion to strike.
Q. So that would be at what levels?
A. Well, the fusion was at 5-6. Then it has to be at 4-5 and at 6-7. After six or eight years, this patient may develop arthritis at those points.
Q. Would these future problems, such as arthritis, affect her ability to perform usual activities as we previously discussed?
MR. HANRATTY: Objection.
A. That is difficult to say, because she doesn't have arthritis at this time. Then at this time she is not restricted in any way.

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MR. SOLES: Thank you, Doctor, for helping us better understand Mrs. Shanower's medical condition. I have no further questions at this time.
THE WITNESS: You're welcome.
- - - - - - -
CROSS-EXAMINATION
BY MR. HANRATTY:
Q. Hello, Doctor. My name is Jim Hanratty. I represent Charlie Holcomb in this case. Based upon your testimony, I've got a few follow-up questions.
You indicated that as part of your initial evaluation of Mrs. Shanower you took a history froin her. And that's a general part of your examination and treatment of any patient; correct?
A. Yes, sir, correct.
Q. And you said a history is basically asking the patient what hurts, how did things happen, just getting the facts about what brings the patient to see you; isn't that right?
A. That's correct.
Q. You would agree with me that obtaining a detailed and accurate history is an important part of your

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diagnosis and treatment of any patient, including a patient such as Della Shanower?
A. Any patient.
Q. You will agree with me that if the history is inaccurate or incomplete, that can alter the opinions that you eventually come to based upon that history; right?
A. Or misleading, if the history is misleading. But we have to rely upon the patient.
Q. You have to rely upon what information you obtain in your history; correct?
A. Absolutely.
Q. Now, Doctor, you never treated Mrs. Shanower before this 1996 accident; correct?
A. I never met her before, no, sir.
Q. In fact, I think you told us that you didn't see her for a year after this accident.
A. I saw her in September the following year after the accident.
Q. So if this accident happened in July of 1996, and September of 1997 was when you saw her, that's more than a year later; correct?
A. Yes, fourteen months.
Q. Did you do a review of her past medical records prior to today?

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A. I don't understand your question.
Q. I'm sorry. You told us earlier in your examination that -- I think you said you reviewed the exhibits that you discussed a few minutes before your deposition?
A. Yes, a few minutes before we came here, your colleague who I meet with, copies of the evaluation by the physical therapist while she was not yet my patient in 1996 and evaluations of the physical therapy group while she was not yet my patient in 1997.
Q. Had you seen a complete set of Dr. Galang's records for the period of time before Mrs. Shanower was your patient?
A. I looked briefly at photocopies of Dr. Galang's records.
Q. When was that, before the surgery?
A. No, I looked now.
Q. Oh, just here today?
A. Today.
Q. But you hadn't had the opportunity to review any of her treatment records from treatment before she came to you before you did the surgery; correct?
A. The only ones that I read were tlie notes by the

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physical therapists. These I read. Dr. Galang's I just looked quick, but I read the notes by the physical therapists.
Q. Did you review the July 9, 1996, records from the Columbia Mercy emergency room before you came to your opinions in this case?
A. I reviewed the records that would qualify that she has cervical sprain and was sent home on an anti-inflammatory.
Q. Did you review those just before your deposition today or was that earlier on?
A. I can not recall. I saw them today for sure. I don't know if I saw them before I operated the patient or not.
Q. Doctor, would you agree with me that your understanding of what happened that brought the patient to you is based largely upon what either the patient herself told you or what the patient's lawyer told you?
MR. SOLES: Object.
A. No, the patient's lawyer, I hadn't met him until today.
Q. But you had corresponded with him certainly?
A. I sent him a letter, this report. You might have a copy of tlie report reauested by his office.

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Q. Right.
A. No, it was based on what tlie patient told me, and I think I had a phone conversation before surgery with Dr. Galang, but basically it was based on the information provided from the patient.
Q. From the patient. Okay. And like you said, that's generally what you do any time you're treating somebody?
A. Yes.
Q. Doctor, would you explain the term radiculopatliy to us?
A. Yes, sir. At each level of the spine, as we say, cervical, lumbar, any level, there are two nerves coming out. In this case they are called cervical nerves. They are also called nerve roots. And the nerve radiculopathy comes from tlie same word root. Radiculum in Latin is root in English. Then radiculopathy means involvement of tlie radicular nerve or the nerve, just to make it simple, at that level.
Q. Is my understanding correct, that radiculopathy generally causes numbness and tingling at the end of that nerve where tlie -- you're talking about the nerve root, but I mean further on down tlie nerve?

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A. This is fifty percent correct, because the nerves -- tlie cervical nerves are mixed nerves. It means there are motor and there are sensory nerves. There are two components. Then a radiculopathy in one of these nerves will cause maybe only motor, like weakness, motor symptoms, decreased reflexes, maybe only sensory, like you mentioned very well, tingling, numbness, less sensation, or maybe both. it depends on tlie degree of involvement or compression or injury to tlie nerve.
Q. Doctor, will you agree with me that radiculopathy is often a telling sign of a disc herniation?
A. Yes.
Q. And the numbness and tingling of that radiculopathy is caused by something pressing on the nerve root. Is my understanding correct?
A. Yes. Not always -- excuse me for the interruption. Not always it could be numbness and tingling. Maybe the patient has only weakness or has numbness and tingling and pain or has both.
Q. Doctor, you'll agree with me that disc herniations can be caused by many different things, won't you?
A. Yes.
Q. In fact, in this case you believe that tlie

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herniation was caused by trauma, but herniations can also be caused by things like degeneration or wear and tear type injuries; correct?
A. Degeneration, yes.
Q. It can also be caused by congenital problems at times; is that right?
A. I don't think too often, but basically lifting, trauma, and sometimes for no reason.
Q. Isn't it true that the vast majority of disc herniations are caused more by degeneration or wear and tear through age and frequent use than by a single traumatic event?
A. Yes, more from wear and tear, because by degeneration, what happens, the disc loses the water component, the length in the interspace decreases, and most of the time the patients develop arthritis and osteophytes. But most of the time it's wear and tear for no reason. I have patients that have an acutely herniated disc just after an episode of coughing, you know.
Q. So traumatic disc herniations are more rare than those caused by other factors; correct?
MR. SOLES: Object.
A. Let's put maybe thirty percent.
Q. And those traumatic disc herniations, those are

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generally characterized or associated with a sudden onset of radiating pain, correct, numbness or weakness, like you said earlier, a sudden onset?
A. What happens, for the information of the jury, the disc, the soft material is surrounded by a hard capsule. And when there is a trauma, sometimes the capsule comes completely open, breaks, then the disc will come out. But most of the time what happens, they have what we call radial, like a radius, like in a wheel, a spinning wheel, radial tears. And over the ensuing months, over the following months, those tears may advance further and the material may come out two, three, four months later. But there are two forms.
Q. Doctor, you used a term a couple answers ago that I didn't quite understand. You used the term osteophyte. What is that?
A. Osteophyte is what people call a bone spur.
Q. A bone spur?
A. A bone spur.
Q. And you said in a degeneration or a degenerative disc herniation you will often see osteophytes?
A. We may see osteophytes, especially if the disc is

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gone. Most of the time there is no disc material, there are only osteophytes.
Q. Doctor, Mrs. Shanower was originally diagnosed at the emergency room as suffering from a muscle strain or sprain; correct?
A. Yes. I don't remember which date. I think it was -- I saw that emergency room report. Do you know which exhibit that is?
MR. SOLES: Exhibit 2, Doctor.
A. On 7-9-96, yes, acute right cervical muscle strain; acute right thoracic spine, paraspinal muscle strain. And this was when she first went to the emergency room on July 9, 1996.
Q. Those records don't show any complaints of numbness or tingling, do they?
A. Well, those records don't have any history and physical. Oh, yes, excuse me. Strike that. I was looking at the emergency room note. Those records do not reflect any numbness or tingling, no sensory deficit.
Q. In fact, the homegoing instructions or what the medical staff at Mercy Hospital told her when she was leaving was that if in fact she experienced any numbness or tingling, she should come back to the hospital; isn't that right?

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A. I'm looking for that statement. Return if pain worse, numbness, weakness in arms or legs.
Q. So the hospital said if she had any worsened pain, numbness or weakness --
A. To return.
Q. -- in her arms or her legs, to return; correct?
A. Yes.
Q. Do you know if she went back to the emergency room?
A. No.
Q. Is it correct that the hospital gave her this information because that would be signs of disc herniation or nerve root involvement?
A. Possibly.
Q. And again, she did not return to the ER; correct?
A. Yes, correct, according to the information I have here.
Q. Doctor, when you were giving us some information regarding your several opinions in this case, you said that your opinions were based upon a series of facts; correct?
A. Yes.
Q. And the series of facts, is that relating back to that discussion of history that we had before?

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A. My opinion that this probably was caused by the autoinobile accident, yes, was based on a series of facts.
Q. And the series of facts, is that the history that we talked about earlier?
A. The series of facts is, number one, that she never had any coinplaints regarding her neck prior to this injury. Number two, that from the very same day she had the injury, she started complaining of neck pain continuously for several months. Number three, that she was not studied properly, because she never had any x-rays or CT scan at the time of her first visit to Dr. Galang or to the emergency room. Then with no x-rays, they couldn't diagnose this disc. She went to Florida for a month. She didn't have a physician in Florida, but when she returned she went to see Dr. Galang again with the same coinplaints of neck pain. Dr. Galang proceeded in the same standard procedure by referring her to physical therapy. And it is only when the physical therapy realized that the pain has increased, when she was referred back to Galang, Dr. Galang ordered a CT scan and there is a large disc.
This is why I say my opinion -- to make it

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shorter for the benefit of the jury -- is that this woman didn't have any neck pain or any ailments of the neck before the accident, but following the accident for fourteen months continual neck pain. It is fourteen months after the accident or thirteen months when finally she has the appropriate study. That is a CT scan. The study shows a cervical herniated disc. Then it is operated. This is why I think there is a direct relationship between the injury, based on my information, between the injury and the ruptured disc.
Q. So at least part of that series of facts is an assumption that the symptoms never improved from the date of the accident to when you saw her; correct?
A. Yeah. I don't know -- it's an assumption, because I don't have any documentation about what happened in Florida, but she didn't visit any physician I think.
Q. Doctor, were you made aware at any point, other than today I guess, that during the initial range of physical therapy prescribed by Dr. Galang that Mrs. Shanower was able to lift weights, rotate her arms, use elastic resistance, as well as other

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forms of exercise without any complaints?
A. Yes.
Q. You were aware of that?
A. I read the notes. And they don't say within normal limits. They say something different, that her activities -- they didn't say they were within normal limits. Do you know which exhibit that is?
Q. Excuse me. I think we'll get to them in a second in detail. Were you made aware that on August 7, 1996 -- and these are Dr. Galang's records -- less than a month following her accident, Mrs. Shanower reported an increased range of motion and decreased pain in her neck? Were you aware of that?
MR. SOLES: What records are you referring to?
MR. HANRATTY: August 7, 1996, Dr. Galang.
A. No, but this, I think it is fine. This is possible --
Q. Excuse me. Were you aware of that or not?
A. No, I was not aware of that.
Q. Were you aware or were you made aware by anyone that by August 12, 1996, Mrs. Shanower reported

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that she felt that her motion had returned to normal? Were you aware of that, Doctor?
A. No, I am not aware of that, but it doesn't mean anything.
MR. SOLES: I don't believe those are Dr. Galang's records. I believe those are the records of the physical therapist, just to clarify the record. Is that correct, Jim?
MR. HANRATTY: I have no idea. I thought it was Galang, but I'm not going to question it.
BY MR. HANRATTY:
Q. Were you aware that the physical therapy records indicate that by August 19, 1996, Mrs. Shanower was able to, and I'll quote, tolerate an extensive exercise program well? Were you aware of that fact?
A. Yeah.
Q. You were aware of that?
A. No, I wasn't aware of that.
Q. You were not. Were you aware that for a period of time between August of 1996 and August of 1997, Mrs. Shanower did not require the use of any pain medication or muscle relaxers for her neck? Were

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you aware of that?
A. I think she was in Florida.
Q. Right. Do you know whether she was taking pain medication or muscle relaxers?
A. No, I don't. But to be aware or not be aware doesn't have any bearing on your position or on my position.
MR. HANRATTY: Motion to strike as being nonresponsive to the question.
Q. I guess in summary, Doctor, the history you were given said that there was absolutely no improvement, correct, and that was your assumption?
A. Which history?
Q. The history you got through the patient and upon which you based your opinion. I think you told us earlier that that was part of the series of facts, that there had been no improvement for a year or so.
A. Well, she had constant pain according to the history that I got from the patient.
Q. And the history that you obtained froin the patient is part of what you based your opinions on in this case; correct?
A. Yes.

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Q. Doctor, handing you what has been marked as Defendant's Exhibit A, would you take a look at that document for me? Have you seen this document before today?
A. No.
Q. Had you reviewed it as part of the history you obtained?
A. No, I never saw this document before.
Q. This is a medical report similar to the one you sent to Attorney Soles; correct? It's a medical report?
A. I didn't finish to read.
Q. I'm sorry. Go ahead.
A. I'm on the second paragraph.
Q. I'm sorry. I'm getting ahead of myself.
A. No, you're all right. Well, it's a medical report, but -- Yes, I read it now.
Q. That is a medical report from Dr. Galang to Attorney Centrone; correct?
A. Attorney Centrone represents the patient too?
Q. I believe so, yes.
A. Okay.
Q. What's the date of that report?
A. October 28, 1996.
Q. So that's just a little less than a year before

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you first saw the patient; correct?
A. Yes.
Q. Now, in this medical report, Dr. Galang tells Mr. Centrone that --
MR. SOLES: Objection.
Q. -- in August of 1996, although she still has some minor aches and pains, she has improved considerably; correct? Do you see that?
A. Yes, the last, has improved considerably, complained of minor aches and pains regarding her neck and upper back but has improved considerably.
Q. Has improved considerably. And that's what her family doctor told her lawyer; correct?
MR. SOLES: Object.
A. Yes.
Q. Doctor, are you here to criticize the treatment, diagnosis, or opinions rendered by Columbia Mercy Hospital physicians or Dr. Galang?
A. Yes.
Q. You're criticizing their treatment?
A. Galang is wrong.
Q. Doctor, we talked about -- I think you went through some medical bills.
A. If you want, I can specify further.
Q. I'm sure if Mr. Soles wants you to, he'll ask you.

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You told us about these bills, and I think they were Exhibits 10 through something.
MR. SOLES: 16.
Q. 10 through 16. Thanks.
A. 10 through 16. Could I --
Q. Yes, I'll give you a second to grab them. I'm going to be directing your attention to Exhibit -- I believe it's 16, which are --
A. 16?
Q. Yes, prescription records.
A. Yes, sir.
Q. Now, you testified on direct examination that some $331.27 worth of prescriptions were all related to this accident; correct?
A. How much, three hundred and what?
Q. $331.27. I'm reading from the summary that's on it, so I'm not going to question your math on the --
A. No, no, it's here. It's $352 and then $44. But this is not from Columbia Mercy. This is a customer history report. You asked me to look at that. I don't have any other. I have only these two, Exhibit 16.
Q. Yes, that's what I'm looking at, Doctor. That's what I'm looking at. That's a prescription

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record?
A. But this is not from Columbia Mercy, This is the medical history of the customer. This probably is by a pharmacist.
Q. Okay. I think you're right. I think it's a record of prescriptions that have been filled by a pharmacy somewhere on East Tusc.
A. Yes.
Q. And these are all for Della Shanower, correct, based upon what you can tell from the record?
A. Yes, they are for Della Shanower, but this doesn't mean that they are related to the neck injury, you know.
Q. Well, that's what I'm trying to get at. I was a little confused, because on your direct examination Mr. Soles had you qualify these as being related.
A. No, I was referring to these bills. These are the bills that he asked me to look at.
Q. Go ahead and look at that. That's a summary, I believe, And look at the last page of what that is, the final page. I believe that's the same thing that we're looking at.
A. I thought we were talking about the operation.
Q. Well, that's why I was confused, because part of

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the bills that Mr. Soles had you claim were related are these prescription bills, and it looks to me like one of the drugs is what's called Dicyclomine, and that's for relieving a GI tract spasm. Correct?
A, Well, I fully agree with you, because the bills that he asked me to look is this, that it is related to the hospital admission for my surgery. And these bills are the history of a pharmacy located on Tuscarawas Street. It is not Mercy Hospital. And there are prescriptions by Dr. Bazzoli, a gynecologist, Columbia Mercy, Dr. Galang, Dr. Galang, and there are three or four prescriptions by me. This must be the pharmacy that the patient is a customer, and of course there are prescriptions related to the so-called injury in the neck and prescriptions unrelated.
Q. And that's why I was confused, Doctor.
A. Me too.
Q. Because I think you did say that these $331 or so worth of prescriptions --
A. I was talking about this from the hospital.
Q. Right. But the document that we're talking about is made up on that. And I thought that there were

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some unrelated bills. And I was right; correct?
A lot of those bills are unrelated; correct?
A. Yes, some of these bills are not related probably. I don't know.
Q. There are bills for hypertension on that list; correct?
A. There is Premarin, Cyclobenzaprine, Dicyclomine, Vaseretic, that's a diuretic, that's for hypertension, Promethazine, Cipro for urinary tract infections, Lotrisone cream, Vaseretic. Then some of these bills are questionable.
Q. In fact, there are bills there for things like Zantac; correct?
A. Yes.
Q. Things like Lotrisone cream, that's for skin infections?
A. Yes, it is unrelated.
Q. There's another -- and I'm sure I'm going to butcher the pronunciation, Diphenoxylate/Atropine. That's for diarrhea?
A. I'm glad you pronounced. I wouldn't be able to. Yes. But I agree with you that it is confusing for us, because probably maybe there are only two or three with my name that inust be for that.
Q. Doctor, you'll agree with me that Della Shanower

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has made a full recovery; correct?
A. At this time she is fully recovered.
Q. At this time you anticipate no further treatment related to this injury?
A. At this time no further immediate treatment, yes.
Q. And at this time you anticipate the need for no further medical expenses; correct?
A. At this time I anticipate that.

MR. HANRATTY: Thank you for your time, Doctor.

MR. MATASICH: I have no questions, Doctor.

MR. MOSS: I have no questions.

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REDIRECT EXAMINATION

BY MR. SOLES:

Q. Doctor, I just have a few questions. In your cross-examination by Attorney Hanratty, he referred to some physical therapy records by Louisville Physical Therapy. Specifically on August 12, 1996, he read to you the following, "Patient presents today reporting that she feels that her motion has returned to normal." Okay? But what he failed to read was the remaining part of that that says, "But when she holds her head in

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tlie rotated position either way, she has increased muscular pain." Okay, Doctor? Subsequently on August 14th of --

MR. HANRATTY: Excuse me. Was there a question at the end of that statement?

Q. Could you review that?
A. Which?
Q. It is Plaintiff's Exhibit 4, Doctor, approximately six or seven pages in.
A. Okay, Exhibit 4.
Q. Go in about six or seven pages or so. Right there, Doctor.
A. On 8-12?
Q. Yes. Do you see where after it says "returned to normal" that there is additional language there, Doctor?
A. Yes.
Q. Could you read that?
A. It says, "Patient presents today reporting that she feels that her motion has returned to normal, but when she holds her head in the rotated position either way, she has increased muscular pain."
Q. Now I refer you down to August 14, 1996, two days later. Can you read what that says?

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A. "Subjective: Patient presents today reporting that she has continuing pain in the cervical spine with any type of active motion."
Q. Doctor, there's been some misunderstanding, I guess, or miscommunication relative to the medical bills that I've had you identify, specifically the prescription records.

Could you go through and identify for us what -- and this may have been my own fault -- what medical bills are reasonable and necessary as a result of this accident starting with July 9, 1996, which is the date of the accident? And I won't even begin to pronounce that, but it's Cyclobenzaprine I guess.

A. Well, I think the first one, Premarin, is out, strike, because --
Q. Obviously 7-9-96, that's the date of the accident, that would be a --
A. 7-9 is related to the emergency room admission.
Q. Then you have your records beginning on October 14, 1997?
A. Yes, I prescribed that to protect tlie gastric mucosa because I was giving her Dexamethasone. Then the 10-14-97 Ranitidine, tlie 10-14-97 Dexamethasone, the 10-17-97 Dexamethasone, and the

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10-17-97 Cimetidine, they are related to.
Q. What were all those medications used for, Doctor?
A. The Cimetidine and Ranitidine are to protect the gastric mucosa, because the Dexamethasone, that is a very strong anti-inflammatory, could cause acute peptic ulcer and bleeding.
Q. So you believe all of those charges are reasonable and necessary?
A. The charges on the five that I have identified, I think they are related. The rest, no.
Q. We've heard some discussion from Mr. Hanratty with respect to degeneration, also with respect to I guess the delay, the fact that you saw her a year later. Has any of the discussion that he's brought to your attention changed your opinion that the auto crash caused Mrs. Shanower's disc herniation?
A. If the information that I had is accurate and truthful, it wouldn't change my criteria.
Q. So what is your opinion, Doctor, just to state it for the jury?
A. My criteria, my opinion based in this case as well as in my experience with many other patients is that a flexion-extension injury to the neck in a motor vehicle accident may cause and causes as a

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matter of fact many times injury to the joints of the neck, what we call discs, and'one, two, three months later or immediately the patient may end up with a herniated disc and most of the time it has to be operated. This is my honest opinion.
Q. And in this case there was no x-ray, MRI, or CT scan taken until September 8, 1997; correct?
A. Yes, there were no other studies done.
Q. And that was the first time that there was an indication that there was a herniated disc?
A. Yes.

MR. SOLES: Thank you, Doctor.

MR. HANRATTY: No other questions. Thank you.

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(The deposition was concluded at 3:30 p.m.)

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CERTIFICATE

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

I, Linda McAnallen, a Stenographic Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named Witness, ALEJANDRO SOS, N.D., was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; Lhat the testimony so givon by him was by me reduced to Stenotype in the presence of the witness, and that the foregoing is a true and correct transcription of the testimony no given by him as aforesaid.

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

1 further certify that I am not a relative, counsel or attorney of either party nor otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cuyahoga Falls, Ohio, this 11th day of January, 1998.

Linda McAnallen, Notary Public
ny commission expires July 24, 2000.