

IN THE COURT OF COMMON PLEAS

PORTAGE COUNTY, OHIO

- - -

DEBORAH MAZANEC, et al,)

Plaintiffs,)

vs.) Case No. 98-CV-00725

THERESA MCDOWELL,)

Defendant.)

COPY

- - -

Deposition of TARVEZ TUCKER, M.D., a Witness herein,
called by the Defendant for cross-examination pursuant to
the Rules of Civil Procedure, taken before me, the
undersigned, Laura E. Pavlick, RMR and Notary Public in and
for the State of Ohio, at the offices of Dr. Tarvez Tucker,
Fifth Floor, Hanna House, University Hospitals, 11100
Euclid Avenue, Cleveland, Ohio, on Thursday, the 22nd day
of February, 2001, at 10:00 o'clock a.m.

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APPEARANCES:

On Behalf of the Plaintiff:

Messrs. Becker & Mishkind Co., LPA

By: Howard D. Mishkind, Attorney at Law
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Cleveland, Ohio 44113

On Behalf of the Defendant:

Messrs. Giulitto & Berger

By: Paula C. Giulitto, Attorney at Law
222 West Main Street
Ravenna, Ohio 44266

- - -

1 TARVEZ TUCKER, M.D.

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

5 CROSS-EXAMINATION

6 BY MS. GIULITTO:

7 Q. Dr. Tucker, we just had an opportunity to meet
8 each other just before we began this deposition. **My** name
9 again is Paula Giulitto and I represent Ms. McDowell in
10 this lawsuit. It's my understanding that you had occasion
11 to meet Ms. Deborah Mazanec at some point in time; is that
12 correct?

13 A. Yes.

14 Q. Before I start asking you questions, Dr. Tucker,
15 have you ever had your deposition taken before?

16 A. Yes.

17 Q. Okay. So you are familiar with the standard rules
18 about answering all the questions audibly, not doing the
19 nods and shakes of the head because it's always difficult
20 for Laura to take down?

21 A. Yes.

22 Q. Okay. Can you tell me how you came to meet
23 Deborah Mazanec?

24 A. Yes. She was referred to our pain management
25 center by Dr. Annette Bressi, and I first saw her on

1 September 14th of 2000.

2 Q. Okay. Is that your file that you're looking at?

3 A. Yes.

4 Q. Can I take a look at that, please?

5 A. Yes.

6 Q. Okay. For the record, prior to the deposition
7 beginning I was only provided with four pieces of paper,
8 that being your written, or typed report for exam date
9 October 26th, Year 2000, your handwritten follow-up
10 evaluation of that same date, and a report that you wrote
11 to Dr. Bressi on September 14th.

12 When I came here this morning you presented me
13 with some additional records out of your file, but it
14 appears that I am now looking at one piece of paper that I
15 still do not yet have, and that would be the initial
16 evaluation handwritten notes from September 14th. Could I
17 get a copy of that?

18 A. Are these the three pages you are referring to?

19 Q. I do not have those.

20 A. Okay. They're blank. This is just a form with
21 only her name on it, but it's not filled out at all. You
22 are welcome to have it, but they're blank.

23 Q. Okay, that's fine. I would just like to have
24 everything that's in your file just so there is no
25 confusion about me not having some piece of paper.

1 A. Okay.

2 Q. There is also the Robinson Memorial Hospital
3 physical therapy initial evaluation form that although I
4 was, I don't believe I received a copy through your file, I
5 do have a copy through the hospital's file, so that's
6 fine.

7 You know, I would like a copy of this, too,
8 just her prescriptions in the back. We don't need to do
9 that right now, we can do that at the end, that's fine.

10 A. Okay.

11 Q. Okay? There you go, don't want to mess up your
12 file.

13 Dr. Tucker, when Ms. Mazanec came in did she
14 complete a history form for you?

15 A. Yes.

16 Q. And is that this patient questionnaire --

17 A. Yes.

18 Q. -- which I have? On the top it says, referring
19 M.D., and M.D. is marked out and it says referring doctor,
20 Howard Mishkind. Would that have been something that Ms.
21 Mazanec filled out?

22 MR. MISHKIND: It says referring attorney,
23 Howard Mishkind, not referring doctor.

24 MS. GIULITTO: Well, it was referring M.D., and
25 M.D. was crossed out by someone and the word "attorney" was

1 written in, so it says attorney referring, Howard Mishkind.

2 MR. MISHKIND: Right, you said attorney. You
3 said referring M.D., Howard Mishkind, I was just correcting
4 you.

5 MS. GIULITTO: Okay. I will take away your
6 medical license.

7 MR. MISHKIND: Haven't gotten it yet.

8 BY MS. GIULITTO:

9 Q. Is this information that Ms. Mazanec would have
10 filled out?

11 A. Yes, this is her handwriting.

12 Q. Is it your understanding that the reason Ms.
13 Mazanec came to you was because of her attorneys sending
14 you, sending her here or her doctor, if you know?

15 A. I don't recall.

16 Q. Doctor, is neurology your area of specialty?

17 A. Yes.

18 Q. And how long have you been practicing in this
19 area?

20 A. I graduated from medical school in 1980 and I
21 accepted a position of an Assistant Professor here in 1987
22 following my residency.

23 Q. So fair to say you've been doing this 13, what is
24 it, 13, 14 years?

25 A. 14 years.

1 Q. Okay. On the second page of the patient
2 questionnaire it looks like these are your notes; is that
3 correct?

4 A. The examination was filled in actually by my Pain
5 Fellow, Dr. Sing.

6 Q. Okay.

7 A. And that's his handwriting.

8 Q. Under the motor, upper extremities and lower
9 extremities, can you tell me what that says?

10 A. It says 5 slash 5, which means that her motor
11 strength was normal, and there was normal tone in both
12 upper and lower extremities.

13 Q. Does that basically mean that she had no motor
14 deficiencies at that time?

15 A. That's correct.

16 Q. And under sensory, what does that say?

17 A. It's D to P, meaning a distal to proximal gradient
18 of diminished perception of pin prick.

19 Q. Can you explain that for me, please?

20 A. That means that in her hand, it was actually her
21 left hand, which she doesn't delineate here but it's in the
22 dictation, there was a diminished perception of sharp, a
23 sharp modality that was worse distally and got better
24 proximally in the hand.

25 Q. Okay. So that I am understanding and so that

1 Laura's notes are clear, does that mean she could feel the
2 pin pricks more in the base or palm of her hand than she
3 could in her fingertips?

4 A. Exactly.

5 Q. The next page is history of present illness, and
6 it asks for some information such as symptoms, tests,
7 treatments and surgeries. Was this information that was
8 completed by Ms. Mazanec?

9 A. Yes, and then reviewed by us with her.

10 Q. Same thing with the next page, which is medications;
11 that would have been something that she completed?

12 A. Yes.

13 Q. Okay. Doctor, in addition to your associate, I
14 think you said **Mr.** Sing or Dr. Sing --

15 A. Yes.

16 Q. -- did you have occasion to examine Ms. Mazanec on
17 that September 14th visit?

18 A. Yes. I always examine the patients either with or
19 after Dr. Sing does the initial evaluation.

20 Q. And can you tell me what you did during your
21 examination?

22 A. We assess sensory, motor, reflex examination and
23 cerebellar.

24 Q. Okay. And what is cerebellar?

25 A. That's coordination.

1 Q. Okay.

2 A. And take notes usually just following the
3 examination and then summarize it after the patient has
4 actually left with a full dictated report, which you have.

5 Q. And is that the September 14th report to Dr.
6 Bressi?

7 A. Yes.

8 Q. Would it be fair to say that in that report then
9 you basically related information Ms. Mazanec gave you in
10 that she indicated she has had constant pain since an
11 accident in November of 1997?

12 A. Yes. And we were, actually made an error; the
13 accident was in September of '97.

14 Q. It's a typographical error, that's fine. You
15 reference some injections that she underwent in January of
16 1999 in the first paragraph of your report. Are you aware
17 of who gave her those injections?

18 A. I am now.

19 Q. Okay.

20 A. Dr., the other Dr. Bressi, the pain
21 anesthesiologist I believe married to Annette Bressi did
22 both epidural steroids and also sacroiliac joint
23 injections.

24 Q. Were you aware that Dr. James Bressi had given Ms.
25 Mazanec those injections when you issued this report?

1 A. I may not have known the name of the doctor. I
2 didn't list it here.

3 Q. Okay. Can you tell me how you know today that it
4 was James Bressi?

5 A. I reviewed them with Mr., I was going to call you
6 Dr. --

7 MR. MISHKIND: That's okay. Go right ahead, be
8 consistent.

9 THE WITNESS: -- in my office in the last hour.

10 MS. GIULITTO: Okay.

11 MR. MISHKIND: Off the record.

12 (Discussion had off the record.)

13 BY MS. GIULITTO:

14 Q. Would it also be fair to say as a result of your
15 report that when you saw Ms. Mazanec she denied any
16 problems that she was having, such as tingling or numbness
17 in her hands and feet, weakness of any bladder or bowel
18 dysfunction?

19 A. Yes.

20 Q. And that was important for you to note for what
21 reason?

22 A. Those symptoms might indicate a certain kind of
23 neurologic disorder, such as radiculopathy, for example, or
24 peripheral neuropathy. It's our screening review of
25 systems that we always obtain in taking a full neurologic

1 history.

2 Q. Okay. Her neurological examination, for all
3 intents and purposes, was normal; is that true?

4 A. No. She had an asymmetry of her ankle reflexes,
5 she had one plus at the Achilles' heel on the right and two
6 plus on the left. Two plus in her case is normal.

7 Q. Okay.

8 A. So that she had an asymmetry at her ankles, and
9 that can be due to a variety of things, such as pressure on
10 a nerve root from a disk.

11 Q. Do you have any idea what was causing that
12 asymmetry in Ms. Mazanec's case?

13 MR. MISHKIND: Does she have an opinion? You
14 said any idea.

15 BY MS. GIULITTO:

16 Q. Do you have any idea or an opinion, Doctor?

17 MR. MISHKIND: Let me object, but go ahead.

18 BY MS. GIULITTO:

19 Q. That's fine.

20 A. Yes.

21 Q. Can you tell me what your opinion is?

22 A. In patients with back pain our concern, as
23 neurologists, is not the pain so much, but that the pain is
24 the result of pressure on a nerve root that exits the
25 spinal canal in the lumbar or cervical region.

1 One of the things that we're concerned about
2 checking is reflexes, because it tells us the integrity of
3 the nerve, and the integrity of her nerve to this leg was
4 interrupted.

5 Q. Can you --

6 A. There can be a variety of reasons for that.

7 Q. Can you tell me which nerve that is?

8 A. Yes. It's the first sacral root or in sometimes
9 contribution from the lower lumbar, the **L-5** nerve root.

10 Q. Is there any way to discern which particular nerve
11 caused her asymmetry in this case?

12 A. Yes.

13 Q. And were you able to do that?

14 A. Yes.

15 Q. And tell me how you did that and what you found.

16 A. Because I know that the **S-1**, the sacral nerve root
17 is the one that actually provides for the reflex, so if the
18 reflex is absent or suppressed, as it was in her, by
19 inference there is pressure or abnormality of conduction in
20 the **S-1** nerve root.

21 Q. Are there any objective tests that can be done to
22 confirm your inference?

23 A. Yes. For example, an **EMG** could be done and an **MRI**
24 scan.

25 Q. Okay. And what would an **EMG** scan show you if

1 there was pressure?

2 A. An EMG isn't a scan --

3 Q. Okay.

4 A. -- it's a test of the electrical integrity of a
5 nerve. And it can tell us, although in many cases it
6 cannot, in other words, it's helpful when it's positive, it
7 can tell us whether or not the nerve is conducting
8 electricity abnormally or incompletely.

9 Q. Okay. You said the test is helpful if it's
10 positive. If it's negative, doesn't it show that there is
11 no nerve pressure?

12 A. No, because the clinical examination is your
13 bottom line for nerve injury. EMG only helps you confirm a
14 diagnosis, so that we count on predominantly our clinical
15 examination and support it with electrical tests.

16 Q. Was an EMG ordered in this case?

17 A. No.

18 Q. Why not?

19 A. Actually at the time, and I don't indicate this, I
20 don't remember the conversation with her, but she had
21 already had an EMG. So I might have found that out and
22 didn't get transcribed to the record.

23 Q. If you were aware that the EMG was negative, would
24 that have changed your opinion at all in this case?

25 A. No.

1 Q. Okay. You also said that another diagnostic test
2 that would be helpful is an MRI.

3 A. Yes.

4 Q. And I take it that would be an MRI of what part of
5 the body?

6 A. Of the lumbosacral area.

7 Q. You are aware that an MRI of Ms. Mazanec's
8 lumbosacral area was performed?

9 A. Yes. I believe she referred to it in her notes
10 from March of '99 when it was obtained at Cuyahoga Falls
11 Hospital.

12 Q. Are you aware of the results from that MRI?

13 A. Yes.

14 Q. And what are they, to your knowledge?

15 A. That she had degenerative disk disease and had
16 actually a herniation at L-3-4.

17 Q. Okay. Are you familiar with a test called the
18 diskogram?

19 A. Yes.

20 Q. What is that?

21 A. It's a way of envisioning the disk a little bit
22 more specifically than an MRI scan. MRI shows structure,
23 but not necessarily inflammation. So if a disk is
24 desiccated, that is dried and not doing its cushion job,
25 that's what a disk is supposed to do between the vertebral

1 bodies, sometimes the diskogram can give us very specific
2 information about inflammation or loss of height and
3 actually efficacy of the disk, so it's an adjunctive test
4 to an MRI scan.

5 Q. In this particular case do you think that it would
6 have been a helpful test to have had performed?

7 MR. MISHKIND: Objection. Go ahead, you can
8 answer the question.

9 THE WITNESS: No.

10 BY MS. GIULITTO:

11 Q. Why not?

12 A. The orthopedic doctors generally use that before
13 they operate or to consider surgery, and I did not consider
14 her a surgical candidate on the basis of my clinical
15 evaluation.

16 Q. So you don't -- do you still believe that she is
17 not a surgical candidate today?

18 A. Yes, I do.

19 Q. Are you aware that another physician had requested
20 or indicated that a diskogram would be helpful in
21 diagnosing or at least ruling out whether that area of Ms.
22 Mazanec's back was causing her pain?

23 MR. MISHKIND: Objection. You can answer.

24 THE WITNESS: I just learned that this morning.

25 BY MS. GIULITTO:

1 Q. Okay. Did you learn that from Mr. Mishkind?

2 A. Yes.

3 Q. Ms. Mazanec never related to you in her course of
4 treating with you that that test had been requested of her?

5 MR. MISHKIND: Objection.

6 THE WITNESS: You know, I don't remember
7 specifically, but I certainly didn't refer to it.

8 BY MS. GIULITTO:

9 Q. Okay. When she wrote down the many tests that she
10 has had performed, she did not indicate that a diskogram
11 had been requested but not performed, did she?

12 A. Not to my knowledge.

13 Q. Did you perform any pin prick tests on Ms. Mazanec
14 other than on the hands?

15 A. Oh, yes. We would do all four extremities. We
16 just list the abnormalities, we don't list the normal
17 response.

18 Q. Okay. So if the abnormalities in this particular
19 case -- are you saying the pin prick abnormalities were in
20 her ankle, or were those in the tips of her hand?

21 A. No, in her hand.

22 Q. Okay. Where else would you perform pin prick
23 tests?

24 A. We generally perform it distally in all four
25 extremities, and if there is an abnormality, we'll test

1 proximally; because the way the nerves are injured they're
2 affected distally first, and then retrograde become
3 abnormal. So the way to screen for abnormalities is
4 distal.

5 Q. And she had an abnormality in both of her hands or
6 just one?

7 A. You know, it's not listed here, but on the basis
8 of our final diagnosis, it just was an omission, it was in
9 the left.

10 Q. Okay. So she has deficiency in the left hand for
11 the pin pricks only, correct?

12 A. Correct.

13 Q. Her right hand --

14 A. And, I am sorry, and temperature.

15 Q. Okay. Her right hand and both feet then were
16 normal?

17 A. That's correct.

18 Q. Your diagnosis after seeing Ms. Mazanec on one
19 occasion was fibromyalgia and carpal tunnel syndrome of the
20 left hand; is that true?

21 A. Yes.

22 Q. I need to address these separately for one
23 moment. The carpal tunnel of the left hand has nothing to
24 do with this car accident; is that true?

25 A. That is true, yes.

1 Q. Is it also true that if you have carpal tunnel in
2 your left hand, that that could cause an abnormality in the
3 pin prick test?

4 A. Yes.

5 Q. Were you relying on anything else other than the
6 abnormality in the pin prick test on her left hand and the
7 abnormality in her temperature when you arrived at the
8 diagnosis of fibromyalgia?

9 A. Yes, we relied on other things.

10 Q. Can you tell me what you relied upon?

11 A. The clinical diagnosis of fibromyalgia includes,
12 as necessary for the diagnosis, the presence of multiple,
13 usually 18 very specific tender spots in the body called
14 trigger points or tender points.

15 Q. Okay.

16 A. And she had those in the appropriate places,
17 bilateral upper arms, shoulders, interscapular area, which
18 actually is predominantly the trapezius, lateral buttocks
19 and medial patellar areas.

20 Q. I don't see any notation in here about any
21 tenderness in the patellar area.

22 A. Right. I am giving you what the places for
23 diagnostic criteria are. We listed the ones that she had.

24 Q. Okay.

25 A. And they were commiserate with those to make the

1 diagnosis in general.

2 Q. Can you tell me how many of these 18 tender points
3 she had?

4 A. No.

5 Q. Is there any diagram in your notes to show where
6 the tender points are and where she had problems?

7 A. No. She has a diagram that she filled out of the
8 areas of pain, and some of those tender points were indeed
9 in these areas, but we didn't diagram them. We normally
10 don't diagram, we make the diagnosis based on the presence
11 of them, and also if they're in atypical locations, which
12 they were not in her.

13 Q. So sitting here today, we don't know how many of
14 the 18 tender points she had?

15 A. I don't remember, no, but sufficient to make the
16 diagnosis.

17 Q. Are there any other factors that you consider when
18 making a determination that someone has fibromyalgia?

19 A. Yes. The diagnosis of fibromyalgia includes
20 chronic pain, generally cervical and lumbar, because those
21 are the high risk areas of the back, particularly following
22 trauma. And fibromyalgia is most common to occur following
23 trauma.

24 In addition, patients describe fatigue, sleep
25 disturbance and often depression. So that in making the

1 diagnosis of, clinical diagnosis, again there is no
2 laboratory tests to make this diagnosis, it's a clinical
3 diagnosis, she fit the criteria for us.

4 Q. Is it your opinion that fibromyalgia is triggered
5 by a trauma?

6 A. It often is, yes.

7 Q. And what do you rely upon in making that
8 statement?

9 A. I actually had reviewed fibromyalgia for us by a
10 talk I gave to the American Bar Association actually
11 downtown Cleveland and have much literature on the cause of
12 fibromyalgia and also whether or not, because many
13 physicians have difficulty with the diagnosis because it is
14 a clinical diagnosis, whether or not there are subjective
15 and objective criteria.

16 I can give you those references. I have got
17 books on the subject and studies and actually a Power Point
18 presentation, if you would like to see it.

19 Q. I would love to see it, but can you tell me what
20 treatises or books or other authors you rely upon in
21 stating to a scientific degree of certainty that
22 fibromyalgia is trauma induced?

23 A. It is not always trauma induced, but it's one of
24 the, it's probably the predominant cause of fibromyalgia is
25 trauma.

1 Q. Okay. And what do you rely upon in saying it is
2 the predominant cause?

3 A. It's a chapter written by Dr. Jennifer Kreigler in
4 a neurology text, there is a book in my office,
5 "Fibromyalgia," I don't recall the author, there is a
6 study done in Sweden actually on a variety of post motor
7 vehicle accident cases of fibromy gia compared with those
8 that weren't caused by trauma; and what was fascinating was
9 whether or not litigation affected outcome, and it did
10 not.

11 So to us that substantiates that it is a very
12 real syndrome and not based just on patients concerned
13 about litigation, prolonging symptoms for that reason. so
14 I have that data for you if you want it.

15 Q. I would before we go.

16 Is it also true that fibromyalgia can be
17 triggered by other things other than trauma?

18 A. Yes, but the most common cause is trauma.

19 Q. I understand that's your position. What other
20 things can trigger fibromyalgia?

21 A. We don't know, we don't know the cause of
22 fibromyalgia. Viral infections have been looked for, for
23 example, the Epstein-Barr virus, because that's felt to be
24 instrumental in causing chronic fatigue, lime disease,
25 which is prevalent in this part of the country, New Jersey,

1 anywhere there are white tailed deer.

2 There are a variety of other possible causes,
3 but it's not known, the actual cause of fibromyalgia is not
4 scientifically known.

5 Q. So it's not scientifically provable.

6 A. Exactly.

7 Q. Would it also be true that an onset of sudden
8 stress or emotional stress could trigger fibromyalgia?

9 A. Not to my knowledge.

10 Q. Is it true that hormonal changes can trigger
11 fibromyalgia?

12 A. Let me just question your use of the term
13 "trigger". Stress can certainly exacerbate symptoms of
14 fibromyalgia. Is it causative, in other words, as a virus
15 causes a meningitis? No. But stress can unquestionably
16 exacerbate symptoms.

17 Q. Okay. Could someone have fibromyalgia, never know
18 it, have a significantly stressful event in their life and
19 all of a sudden become symptomatic?

20 A. No.

21 Q. Okay. So we are back to we don't know what causes
22 fibromyalgia?

23 MR. MISHKIND: Objection. Asked and answered.

24 MS. GIULITTO: This is a discovery deposition.

25 MR. MISHKIND: I objected. Go ahead and ask

1 your question.

2 MS. GIULITTO: I did. Are you instructing the
3 witness not to answer?

4 MR. MISHKIND: Did you hear me say that?

5 THE WITNESS: I am sorry, I forgot the question
6 after that.

7 MS. GIULITTO: Don't feel bad, I did, too.
8 Could you read it back?

9 (The following question was read back by
10 the Notary as requested:)

11 "Q: Okay. So we are back to we don't know
12 what causes fibromyalgia?"

13 MR. MISHKIND: And I objected to that.

14 THE WITNESS: Yes, we don't know the cause of
15 fibromyalgia.

16 BY MS. GIULITTO:

17 Q. You saw Ms. Mazanec a second time; is that
18 correct?

19 A. Yes.

20 Q. October 26th?

21 A. Yes.

22 Q. Starting on your handwritten follow-up evaluation
23 page, are those notes that would have been taken by you or
24 taken by your associate, Dr. Sing?

25 A. Dr. Sing wrote the notes.

1 Q. Were you present when he performed these, the
2 tests that yielded these results?

3 A. Yes.

4 Q. Although Dr. Sing does have very nice handwriting,
5 could you make sure I am not misreading what he wrote under
6 Section B for interval history?

7 A. Do you want me to read it to you?

8 Q. Yes. I just want to make sure I am not --

9 A. Okay. "Symptoms improved since she was started
10 the on Neurontin and Vioxx," that's something that we did
11 at our first visit, "and with aqua therapy. Last weekend
12 she sprained her back while bending over. She is also
13 under stress because of her husband's recent
14 hospitalization due to an MI," which is a myocardial
15 infarction.

16 Q. Okay. Is that a second myocardial infarction?

17 A. No, secondary to.

18 Q. Okay.

19 A. That's what that means.

20 Q. You started Ms. Mazanec on Vioxx?

21 A. No, she had been on Vioxx when she came to us. We
22 started her on Neurontin.

23 Q. Okay. Is that a new medicine?

24 A. Relatively new.

25 Q. And what is the purpose for that medicine to be

1 prescribed?

2 A. Neurontin originally was designed as an
3 anti-epileptic. It's now used far more commonly for pain
4 management, particularly pain due to neuropathic causes.

5 Q. Is that your belief, that she has neuropathic --

6 A. Yes. The pain from fibromyalgia involves nervous
7 tissue, and Neurontin is an excellent choice for nervous
8 tissue pain induced.

9 Q. Under "exam," can you tell me what Dr. Sing's
10 notes say?

11 A. "Alert and oriented times three," that means she
12 knew where she was and who she was and what time it was.
13 Boy, this is --

14 MS. GIULITTO: Off the record.

15 (Discussion had off the record.)

16 THE WITNESS: I honestly can't read this.

17 BY MS. GIULITTO:

18 Q. Is that the second --

19 A. Something long speech. "Cranial nerves 2 through
20 12 are intact," which is evaluation of the cranial nerves
21 to the face and head. "There was present some muscle
22 spasms in her back and tender spinous points over the
23 back." So in a sense a reaffirmation of what we had found
24 on previous examination.

25 Q. Was the recommendation that she continue on the

1 Neurontin, continue with her aqua therapy, and did you
2 issue her a new prescription?

3 A. Yes. We actually increased her Neurontin from 200
4 three times a day to 300. This is still a low dose in
5 terms of therapeutics for pain; and because of the tender
6 spots on her back and the muscle spasm that was palpable,
7 we suggested a muscle relaxant, which is Xanaflex.

8 Q. Had she ever taken that before, to your knowledge?

9 A. No.

10 Q. Was she still taking the Vioxx?

11 A. Yes.

12 Q. That was issued by someone else, I take it?

13 A. Yes.

14 Q. Okay. Are you aware that Ms. Mazanec was, I am
15 not sure at this time, but that she was enrolled in taking
16 yoga classes?

17 A. I don't know if I was aware of it then.

18 Q. Okay. Have you seen Ms. Mazanec since the October
19 26th examination?

20 A. Yes. The last occasion, which was February 8th of
21 this year.

22 Q. Do you have any idea why she selected to come in
23 and see you that date?

24 A. No. Unless we had just scheduled a follow-up,
25 because of course we want to see what happens to our

1 patients, particularly when we change medication.

2 Q. Is there any way to tell when this February 8th
3 examination was scheduled?

4 A. I can find that out for you, but I have no idea.

5 Q. That's fine. Can you read for me the notes on
6 that date?

7 A. Yes. "Ms. Mazanec was seen in follow-up for
8 fibromyalgia. She's doing better on Vioxx and Neurontin,
9 600 milligrams t.i.d." I can't read the next sentence.
10 "And she has no new complaints. Her examination today is
11 unchanged. Our assessment was fibromyalgia, our plan to
12 continue Vioxx, increased Neurontin again now to 800
13 milligrams t.i.d. and continue with a home exercise
14 program."

15 Q. Can you tell me how she got from 300 milligrams of
16 Neurontin to 600?

17 A. It may have been done by phone.

18 Q. Okay. Is there any record of that in your notes?

19 A. Let me look. No record that I can find, but that
20 doesn't mean it didn't occur. We don't always record our
21 phone conversations in the chart.

22 Q. Is Neurontin a narcotic?

23 A. No.

24 Q. To your knowledge is Ms. Mazanec on any type of
25 narcotic prescriptions for pain?

1 A. No.

2 Q. Do you have any plans to see Ms. Mazanec again?

3 A. Yes. Actually our recommendation, but it was a
4 little problematic because of distance, was for her to
5 participate in our four week chronic pain management
6 program. That, from the outset, was our intention.

7 Q. I recall that from your first report.

8 A. Right.

9 Q. Do you know if she has any future appointments
10 scheduled at this time?

11 A. No.

12 Q. Can we find that out once we get off the record?

13 A. Yes.

14 Q. Doctor, at any course in time in your treating Ms.
15 Mazanec have you received records or notes from any other
16 doctors?

17 A. No. I did, however, review some this morning.

18 Q. At whose request?

19 A. At Mr. Mishkind's request.

20 Q. Okay. And what records did he have you review
21 before your deposition?

22 A. Both the, what is their last name, Annette Bressi
23 and her husband's records as well as copies of the reports
24 of the MRI scans performed, the EMG, and in addition the
25 procedure reports for her epidural steroid injections and

1 sacroiliac joint injections.

2 Q. Do you know why Mr. Mishkind asked you to review
3 these before your deposition?

4 A. Do I know why? So that I am up to date and
5 knowledgeable.

6 Q. Do you feel that it would have been helpful for
7 you to have had that information before you treated Ms.
8 Mazanec?

9 A. Well, remember I am not the primary treating
10 physician for her. I viewed her consultation with me as a
11 consultation. She had been cared for by pain management
12 physicians and other doctors that were caring for the
13 problem for which she consulted me. It's not at all
14 unusual for patients to seek a second opinion, particularly
15 when they're frustrated.

16 Q. Okay.

17 A. I would love to have records and I have a letter
18 that goes out to every new patient asking them to bring
19 their MRI scans and any medical records with them. That
20 didn't happen in this case, but I certainly, it certainly
21 makes my job easier.

22 Q. Do you have a copy of the letter that you sent Ms.
23 Mazanec asking her to bring those documents with her?

24 A. We have a standard copy that is sent out from
25 central scheduling. I don't have a copy in her chart.

1 Q. Okay. Do you feel that it was important for you
2 to have reviewed Dr. Bressi, both Dr. Annette Bressi and
3 Dr. James Bressi's records, and all of these tests for the
4 purposes of today's deposition or for the purposes of
5 knowing how Ms. Mazanec was doing before she ever even got
6 to you?

7 A. The event that initiated her chronic pain problem
8 was three years, just more than three years from the time
9 that I first saw her. It would have been much more
10 important had I seen her immediately after the event.
11 Again, I wasn't the treating physician.

12 Given the chronicity of her symptoms and the
13 examination that I obtained, it wasn't important for me to
14 actually view her MRI scan then.

15 MR. MISHKIND: It was or was not?

16 THE WITNESS: Was not. I was able to make a
17 clinical judgment and decision and also a recommendation
18 for her immediate future on the basis of her history and
19 examination.

20 BY MS. GIULITTO:

21 Q. So why was it important for you to see everything
22 today before your deposition, in your opinion?

23 MR. MISHKIND: Let me object. I don't think
24 she said it was important for her. You asked her whether
25 she would have liked to have seen it. I don't think she

1 said it was important, but go ahead.

2 THE WITNESS: No. I mean, it wasn't important,
3 it's something that happened this morning.

4 BY MS. GIULITTO:

5 Q. Okay. Did you request Mr. Mishkind to show you
6 records or reports?

7 A. No.

8 Q. To your knowledge did you ever send a letter to
9 Dr. James Bressi requesting a copy of his records and
10 diagnostic tests that he ordered?

11 A. You know, I don't remember from October, it's
12 something that we often do, and in particular it would be
13 important if she came into the program, because then we
14 would be working with her on a daily basis.

15 Q. Is there anything in your chart that indicates you
16 requested that information from Dr. James Bressi?

17 A. I don't have that. We sent Dr. Annette Bressi the
18 letter, but not Dr. James Bressi any letter.

19 Q. Okay. If you had made a request for records and
20 reports to another physician, would a copy of that letter
21 be in the patient's file?

22 A. Yes. Unless we just asked the patient to obtain
23 them and send them. Sometimes we do that, too.

24 Q. Okay. So would it be fair to say that your file
25 contains no letter to any doctor requesting any records or

1 test results regarding Deborah Mazanec?

2 A. That's correct.

3 Q. Would it also be fair to say that if you had made
4 an oral request to Deborah Mazanec for records and reports,
5 that she didn't bring any to you?

6 A. If we had, yes.

7 Q. Okay. If you had, and I understand we simply
8 don't know.

9 A. Right.

10 Q. Doctor, other than your September 14th, Year 2000
11 letter to Dr. Bressi, have you issued any other letters or
12 reports regarding your treatment of Ms. Mazanec?

13 A. No.

14 Q. Other than Dr. James Bressi and Dr. Annette
15 Bressi, are you aware of any other physicians with whom Ms.
16 Mazanec has consulted regarding this accident?

17 A. No, I don't think so.

18 Q. You are unaware that she was referred to Dr.
19 Tharp? She didn't mention that?

20 A. No.

21 Q. How about Dr. Rausch?

22 A. Mr. Mishkind mentioned Dr. Rausch, her name, and I
23 recall that because I know her.

24 Q. Okay. To be fair I think Ms. Mazanec may have
25 indicated to you that she had an EMG performed?

1 A. She may have.

2 Q. Okay. She probably didn't indicate the doctor who
3 performed that, though, do you know?

4 A. I don't believe so.

5 Q. Did any of the information shown to you this
6 morning cause you to change your opinion of Ms. Mazanec's
7 ailments?

8 A. No.

9 Q. And again, the carpal tunnel has nothing do with
10 this accident?

11 A. That's correct.

12 Q. Are you aware that the MRI taken of Ms. Mazanec's
13 cervical spine was negative?

14 A. Yes.

15 Q. You are aware that the bone scan taken of Ms.
16 Mazanec was negative?

17 A. Yes.

18 Q. Would you agree with me that pain is a subjective
19 finding as opposed to an objective finding?

20 A. Yes.

21 Q. Would you agree that migraines can be a sign of
22 fibro, the existence of fibromyalgia?

23 MR. MISHKIND: Objection. Go ahead.

24 THE WITNESS: There, migraines are what we call
25 a co-variable with fibromyalgia. In other words, they

1 occur with increased incidence in a population of patients
2 that have fibromyalgia. Is there a causation? In other
3 words, does a migraine, does having a migraine make you
4 more vulnerable to fibromyalgia? We have no idea.

5 BY MS. GIULITTO:

6 Q. Does having a migraine tend to be a symptom of
7 someone who has -- I am not asking that question. Let me
8 start again.

9 If someone suffers from chronic migraines, is
10 that a symptom or a sign that they may also be suffering
11 from fibromyalgia?

12 MR. MISHKIND: Objection. Go ahead.

13 THE WITNESS: Actually we know a lot more about
14 migraine, and this happens to be my particular specialty.

15 BY MS. GIULITTO:

16 Q. Great!

17 A. It is a genetic disorder. We are learning much
18 more about what genetic vulnerability there actually is.
19 In a fascinating syndrome called familial hemiplegic
20 migraine, there is a missing chain in chromosome 13. It's
21 probably on the X chromosome because migraine is so much
22 more common in women than men.

23 Twenty-four percent of women in America suffer
24 from migraine, so that there is, to my knowledge, no
25 causation or association between, other than the increased

1 occurrence. It's a genetic disorder and we don't know the
2 genetics of fibromyalgia, or migraine, we are learning.

3 Q. Is it your testimony then that there is no
4 correlation between someone who has migraines and someone
5 who has fibromyalgia?

6 A. Just as I stated, it's a co-variable. So is
7 depression, for example.

8 Q. Someone could suffer from migraines and depression
9 and not have fibromyalgia?

10 A. Oh, yes.

11 Q. What about fatigue, is that a symptom of
12 fibromyalgia?

13 A. Yes.

14 Q. Is it also existent in some people who don't have
15 fibromyalgia?

16 A. Yes.

17 Q. Would you agree that if a person has a lot of
18 stress in their life, that can relate to physical, or cause
19 physical pain?

20 A. Yes.

21 Q. Are you aware of any emotional traumas that Ms.
22 Mazanec had prior to this accident?

23 A. No.

24 Q. Are you aware of any hormonal changes that she had
25 before this accident?

1 A. I know that when she came to us she was on hormone
2 replacement therapy, that's all.

3 Q. Are you aware that prior to Ms. Mazanec being
4 involved in this accident she had been treating for
5 migraines?

6 A. Yes, I think I was, because it was in her past
7 medical history.

8 Q. Are you aware that prior to Ms. Mazanec being
9 involved in this accident she was treated for fatigue?

10 A. Not aware of that.

11 Q. In your opinion is the diagnosis of fibromyalgia
12 different than cervical and lumbosacral myofascial pain?

13 A. Fibromyalgia is by definition a constellation of
14 symptoms and signs which include chronic pain, and it's
15 very commonly in the back.

16 Q. It's the larger diagnosis for the smaller whole?

17 A. Exactly, something like that.

18 Q. Something like that. I don't want to mislead
19 you. Is it that myofascial pain is just one part of
20 fibromyalgia; is that what you are trying to tell me?

21 A. That's correct.

22 Q. Okay. And the other parts of fibromyalgia may
23 include migraines, fatigue?

24 A. Sleep disturbances and depression.

25 Q. Did you find any problems that Ms. Mazanec had

1 with sleeping disorders?

2 A. I didn't record it, but it's something we always
3 ask, so it probably contributed to our diagnosis.

4 Q. Well, if she had indicated she was having problems
5 sleeping, would it not appear in your notes?

6 A. Not necessarily.

7 Q. If someone indicated they were having a symptom of
8 fibromyalgia, you wouldn't include it in your note?

9 A. Not necessarily. We are not as complete as we
10 should be on all occasions.

11 Q. That's probably an admission you should not have
12 made.

13 A. It's part of our diagnosis. We always ask about
14 sleep. She actually didn't include it in her spontaneous
15 notes, but it's one of our inclusions for making a
16 diagnosis of fibromyalgia. In her I don't think it was a
17 predominant symptom.

18 Q. Doctor, understand the purpose of my talking to
19 you today is to find out what symptoms either you found or
20 she related to you that caused you to arrive at this
21 diagnosis.

22 A. Yes.

23 Q. So I am relying on what is written.

24 A. Uh-huh.

25 Q. And so basically what I am seeing that you relied

1 would have recorded it. And again, in chronic pain
2 situations you won't see the kind of autonomic changes you
3 do in acute, such as pupillary dilation, tachycardia,
4 sweating, increased respiratory rate, but it is a very,
5 very real phenomenon to pain specialists as it affects
6 function. So that it's more than subjective, it is also a
7 clinical phenomenon that involves psychosocial issues,
8 psychology and person's every day activity, and we assess
9 that.

10 Q. So when you say it affects their function and
11 their every day activity -- is it something you need to get?

12 A. I can get it in ten minutes.

13 Q. Okay. -- you would look to see how Ms. Mazanec
14 performs in her day-to-day life in the activities that
15 she's involved in to determine her level of functioning; is
16 that true?

17 A. Yes. And that's kind of the things that we want
18 to assess in a chronic pain management program, which is
19 what we recommended for her.

20 Q. Okay. If someone is in a high degree of pain,
21 would it be fair to assume that they are going to engage in
22 less activities?

23 A. Frequently activity can exacerbate pains, yes.

24 Q. So people would tend to shy away from those to
25 avoid the pain?

1 upon for the fibromyalgia, and correct me if I'm wrong or
2 missing anything, is that she had some number out of the
3 total 18 tender points; is that correct?

4 A. Yes.

5 Q. She had migraines, which she also had before?

6 A. I didn't include, I never -- you are the one that
7 included migraines in the diagnosis, I never have.

8 Q. Okay.

9 A. I just told you they were a co-variable. They're
10 not part of the definition.

11 Q. Other than those trigger points then, what else
12 did you rely upon?

13 A. Her history, chronic myofascial pain, which is
14 non-radicular.

15 Q. Which is subjective.

16 A. You know, and you asked me that and I didn't
17 elaborate, but pain management physicians are often asked,
18 particularly in legal situations, pain is a subjective
19 symptom. It certainly is. We don't measure it, there are
20 visual analog scales to measure pain from one to ten, but
21 what we measure is function. And there are, with chronic
22 pain, far less autonomic changes that you can identify; but
23 we are very skilled in recognizing whether somebody **is**
24 elaborating on a symptom or malingering.

25 I didn't have that sense with Deborah or I

1 A. Yes.

2 Q. All right. So we have the some unknown number of
3 tender points, chronic pain, and what else that led you to
4 the diagnosis of fibromyalgia?

5 A. The location of her pain, the paraspinous spasm,
6 the tender points, as you said, and the absence of any
7 other cause for back pain, such as radiculopathy or
8 peripheral neuropathy.

9 MR. MISHKIND: Did you include history in the
10 equation as well I think is one of the things that you
11 said.

12 THE WITNESS: Yes, the history and the
13 longevity. Fibromyalgia is not a six week pain phenomenon,
14 it generally is very long lasting. And her symptoms hadn't
15 changed appreciably in three years following the accident.

16 BY MS. GIULITTO:

17 Q. Okay. She hasn't participated in this four week
18 course that you recommended?

19 A. Not yet.

20 Q. Is it an every day meeting type course?

21 A. It's an every day multi-disciplinary adventure
22 that we have patients from 8 o'clock in the morning until
23 4:30. They are involved in occupational, physical therapy,
24 aquacize, psychology, biofeedback, relaxation techniques,
25 ergonomic work station evaluation, which was something very

1 appropriate for her, and group meetings of patients with
2 similar chronic pain disorders from a variety of causes.

3 Q. And she hasn't participated with this class yet?

4 A. No.

5 Q. But she has seen you on three occasions?

6 A. Right. She, it was a matter of distance.

7 Q. I drove that distance.

8 A. How far is that distance?

9 Q. Probably from where she lives about 40, 45
10 minutes.

11 A. So for every day it would extend her day quite a
12 bit, and there is a lot of physical activity involved in
13 the program.

14 Q. You sent her to physical therapy as part of your
15 treatment?

16 A. Yes.

17 Q. Are you aware that the physical therapy helped her
18 pretty significantly, at least she related?

19 A. She said that therapy helped, and I got a report
20 from the therapist from I believe Robinson Memorial
21 Hospital.

22 Q. Are you aware that she was discharged because she
23 had met all of her goals?

24 A. I do not have a discharge summary. I have an
25 initial evaluation.

1 Q. I am happy to share with you the discharge summary
2 and provide you with a copy.

3 A. She met her goals, and one of the intentions is to
4 continue with aerobic exercises daily, so that's an ongoing
5 recommendation. And for aquatics, which I fully agree
6 with. I think it's one of the best, absolute best
7 rehabilitation plans for patients with chronic pain.

8 Q. It's actually good exercise for anybody, isn't it?

9 MR. MISHKIND: Objection. Go ahead, Doctor.

10 THE WITNESS: Yes.

11 BY MS. GIULITTO:

12 Q. Doctor, would you also agree that whether or not
13 someone suffers from chronic pain or not, it's a good idea
14 health-wise that people exercise?

15 MR. MISHKIND: Objection. Go ahead.

16 THE WITNESS: Yes.

17 BY MS. GIULITTO:

18 Q. Can't hurt them, generally, unless they overdo it.

19 A. Yeah. There are some people that die out on the
20 racetrack there. Particularly, oh, that -- who is that
21 runner who wrote the book on running and then died of an MI
22 while running?

23 Q. I am not talking about that type of running, I am
24 just talking about getting out and getting a little good
25 exercise. It's always a good idea, would you agree with

1 that?

2 A. Yes.

3 Q. Doctor, do you often find that individuals
4 suffering from fibromyalgia have irritable bowel syndrome?

5 A. Actually that's a co-variable for fibromyalgia and
6 also for migraine. So it occurs more often than the
7 general population, but that is still the minority. Do you
8 understand what I mean by a co-variable?

9 Q. No.

10 A. It's something that occurs with another condition
11 at greater than the expected rate epidemiologically, but it
12 may be ten percent versus what you would find four percent
13 in the population. So when I say it's a co-variable, it's
14 not causative, it's not associated with the disorder, it
15 just occurs more commonly in patients that have that
16 disorder.

17 Q. Ms. Mazanec does not have irritable bowel
18 syndrome, does she?

19 A. Not to my knowledge.

20 Q. She doesn't have pain in her abdominal area?

21 A. Not to my knowledge.

22 Q. Is pain in the abdominal area a symptom that you
23 would also find more likely than not in people who have
24 fibromyalgia?

25 A. Diffuse pain is a characteristic of the syndrome,

1 and again the abdominal area is not one that has the
2 characteristic tender points; but can patients complain of
3 pain in that area? Yes, they do, but it's not one of the
4 most common ones.

5 Q. What about constipation, do you feel that that is
6 often the symptom of individuals who suffer from
7 fibromyalgia?

8 A. The difficulty with constipation is that most of
9 these patients are on a variety of medications that can
10 produce constipation. It's very difficult to decipher that
11 out.

12 Q. What the cause of the constipation is?

13 A. Exactly.

14 Q. In any event, Ms. Mazanec is not suffering from
15 constipation, to your knowledge anyways?

16 A. Not to my knowledge.

17 Q. If I could get a copy of your prescriptions in the
18 back there, Doctor, and if we could please find out about,
19 one, when that February appointment was made, if we can
20 find out, and if she has any additional ones, and I am more
21 than happy to let you copy that.

22 MR. MISHKIND: I can do that.

23 THE WITNESS: All right.

24 MR. MISHKIND: Do you want to read or do you
25 want to waive signature?

1 THE WITNESS: Oh, waive, thank you.

2 MR. MISHKIND: Okay. Sure.

3 (Discussion had off the record.)

4 MR. MISHKIND: I will take a copy.

5 MS. GIULITTO: I'd like the original.

6 - - -

7 (Deposition concluded at 10:57 o'clock a.m.)

8 (Signature waived.)

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My Commission expires December 7, 2005.

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