business address for the record.
THE WITNESS: Stuart Hershon, business address is 333 East Shore Road, Manhasset, New York.
THE COURT: Would you please administer the oath officer.
COURT OFFICER: Raise your right hand.
Do you swear, or affirm the testimony you will give today, will be the truth?
THE WITNESS: Yes, I do.
THE COURT: Have a seat, sir. Keep your voice up. It's a difficult room for sound. Please make sure the lawyers can here you, the jury can here you, the court reporter can hear you. We will be fine. If someone can't hear, you let me know. Mr. Gunzburg, you may inquire.

DIRECT EXAMINATION

BY MR. GUNZBURG:

Q. Good afternoon, doctor.

A. Good afternoon.

Q. Doctor, have you and I ever met before today?

A. Yes.

Q. When?

A. Out in the hall.

Q. Okay, that was out in the hallway?

A. Yes.

Q. Other than that time out in the hallway, did we ever meet before today?

A. No.

Q. Okay, now, what type of medicine do you specialize in?

A. I am an orthopedic surgeon.

Q. What type of patients do you treat?

A. I treat people with muscular skeletal problems, people with injuries, sports injuries, injuries to the bones, joints, muscles.

Q. Where do you work?

A. I have two offices. One in Manhasset, which is in long Island, and another one in Manhattan.

Q. And are you currently licensed?

A. Yes.

Q. And where are you licensed?

A. New York State and California.

Q. And what are you licensed in?

A. Sorry?

Q. What are you licensed in?

A. Practicing medicine.

Q. And where did you go for undergraduate?

A. Harvard University.

Q. And where did you go for medical school?

A. New York Medical College.

Q. And did you do a surgical -- withdrawn. Did you do an internship?

A. I did an internship at the University of Michigan

Hospital, Ann Arbor, Michigan.

Q. Did you do a residency?

A. I did residency in two places. Georgetown Hospital in Washington D.C, and the New York Saint Lukes Hospital in Manhattan.

Q. Did you have a specialty in your residency program?

A. Not in those days, no. Oh, Orthopedic Surgery, residency in Orthopedic Surgery.

Q. So you did your residency in orthopedics?

A. Yes.

Q. Now, do you have any kind of affiliation to the New York Yankees?

A. Yes.

Q. What type of relationship do you have with them, or currently have?

A. I was with the New York Yankees Baseball team as head team physician from 1988 until 2009. And now I'm a Senior Orthopedic Consultant and adviser of the Yankees.

Q. And are you Board certificated?

A. Yes.

Q. What does it mean to be Board certified?

A. When you finish your residency and training, you take an examination and you have to past that examination to be certified by the America Board of Orthopedic Surgery. Shows that you learned your skills as a resident and you're able to perform surgery and treat people for orthopedic problems. You can do that without being Board certified, but it's an recognition that you passed the examine and that you have been admitted to the Board based on your character and your past history.

Q. Now, do you have any affiliations to any hospitals?

A. Yes.

Q. And with whom are you affiliated with?

A. I am affiliated with the North Shore Long Island Hospital, Saint Lukes Rooseveit Hospital Center in New York, NYU Langone Hospital in Manhattan.

Q. And have you ever lectured in orthopedics?

A. Yes.

Q. To whom have you lectured?

A. I have lectured to doctors, student residences, and in some cases lay-people, depending on what the circumstances are.

Q. And have you ever published any articles?

A. Yes.

Q. What type of articles have you published?

A. Articles about orthopedic cases, knee, shoulder, different joints.

Q. And have you ever trained residents?

A. Yes.

Q. And where have you trained residence?

A. At the hospitals I mentioned before.

Q. And the residence are – described for us, what are residents?

A. Sorry.

Q. Where are they from, the residence?

A. The residence are doctors in training at the hospitals I mentioned. They are people who have finished an internship and now learn how to be Orthopedic Surgeons at the hospital. So they are taught by people who are on the staff who are what we call attendings, people who currently practice orthopedic surgery and on staff, their title. I am assistant clinical professor of Orthopedic Surgery.

Q. Where do you have that title?

A. At NYU.

Q. And how many surgeries have you actually performed during your career as an orthopedic surgeon?

A. Thousands. I can't tell you exactly but probably maybe 10 thousand. I am not sure exactly.

Q. Okay, and how many surgeries have you done on the knees?

A. Again, thousands.

Q. Have you ever done orthoscopic surgeries on the knees?

A. Yes.

Q. Any other type of surgeries in the knees?

A. In the past I did knee replacements, but I don't do those anymore. And different procedures, reconstruction within the last 15 years are so. Orthoscopic Surgery primarily.

Q. And have you ever testified in court before today?
A. Yes.
Q. And have you ever testified for plaintiff's?
A. Yes.
Q. Have you ever testified for the defendants?
A. Yes.
Q. And tell the jury how many times have you testified for me?
A. Never.
Q. Okay, now --
MR. GUNZBURG: Your Honor, at this time I'd offer Dr. Hershon as a treating expert witness.
THE COURT: Any objection, Mr. Reynoso?
MR. REYNOSO: No.
THE COURT: So qualified.
MR. GUNZBURG: Thank you, Your Honor.
Q. Now doctor, did you have to cancel your schedule to come in here this afternoon?
A. Yes, I did.
Q. What kind of schedule did you have planned?
A. Office hour surgery.
Q. And are you getting paid for the time that you're spending here in connection with this matter?
A. Yes, I am.
Q. And can you tell us, and the jury how much you're getting compensated?
A. I believe it's $6,000.
Q. Okay, and did you review any records in connection with this case?
A. Yes, I did.
Q. And what did you review?
A. I reviewed the charts and records for Mrs. Luna.
Q. Okay, and what were the circumstances under which you began treating Ms. Luna?
A. I first saw her in my office. If you want the date, I have to refer to the chart.
Q. You can. With the permission of the Court, can he refer to the chart?
MR. REYNOSO: Can I shuffle through one

minute. I haven't seen what he is going to look at. Can I shuffle through one minute?

THE COURT: Quickly.

Doctor, can you hand it to him. You can approach.

MR. REYNOSO: Thank you.

THE COURT: You may continue, Mr. Gunzburg.

Q. What were the circumstances under which you began treating Ms. Luna?

A. So, I first saw Ms. Luna on November 4th, 2008. She came to see me nine days after she stated that she fell and she was complaining of pain in her right knee.

Q. Now, did you know -- by the way, you know today that Ms. Luna is a doctor, right?

A. Yes.

Q. Did you know Dr. Luna prior to your treatment of her in connection with this matter?

A. No, no.

Q. Okay, now when she first came to you, did you conduct a physical examination?

A. I did.

Q. And what did the physical examination show you of Ms. Luna's condition?

A. My examination at the time -- now counsel, would you like me to go through the whole thing, or just summarize it.

Q. I would say summarize it.

A. She was complaining of pain in her right knee, and she had some weakness of her right knee. She lacked complete range of motion. She lacked about 5 degrees of what we call extension, the ability to completely straighten the knee out.

THE COURT: She lack 5?

THE WITNESS: Sorry.

A. She lacked 5 degrees. She lacked 5 degrees of extension, so her knee stuck in that position. She was unable to completely straighten it out. Her knee was stable and she had what we call joint line tenderness, which is tenderness at the joint line. What you can feel, what we call grade 3. That

means significant, painful.

She also had what we called questionable positive varus sign where you manipulate the knee and you feel it click, or pop outside the knee.

Q. What does that mean to you, positive?

A. That's indicative sometimes of a torn meniscus, or torn cartilage. So she had pain in her right knee and inability to completely extend it and questionable popping or varus sign.

Q. Did you take a history?

A. Yes.

Q. And what significant finding did it reveal? I have to repeat it.

What did the significant history reveal?

A. She told me she was a pediatrician, that she was on her feet for most of the date. She developed some swelling after injury. She had been seen somewhere else prior to seeing me and she had had an MRI test that was done prior to seeing me and I think I mentioned that she said she was working and on her feet for a considerable amount of time during the day. Other than that, she had a history of knee surgery on her opposite knee. She had no history of cancer. She had an allergy to a medication which was not remarkable in terms of the examination and the rest of her history was not remarkable.

Q. Doctor, she had a history of left knee arthroscopy. What did that mean in terms of her right knee to you, anything?

A. No, in my opinion, it had no relationship to the problem. I don't think it had any relationship to the injury to her right knee.

Q. Now you mentioned the MRIs. We have them in evidence. Did you review those MRI's when Ms. Luna came to you?

A. Yes.

Q. And did you also discuss with Ms. Luna her options at that point and time?

A. Yes, I did.

Q. And what did you tell her?

A. I told her that she had a torn meniscus, or torn cartilage. We use the term interchangeably. And that in all possibility she was going to need an operation, arthroscopic surgery. I advised her to do some exercises to keep her knee strong and I told her I would see her in about two weeks and we'd reevaluate the situation.

Q. And did you see her again in two weeks?

A. I saw her again but wasn't exactly two weeks. I can tell you exactly what date it was.

It was on the 11th of November which I guess was less than two. One, it was one week later.

Q. When she came back one week later what happened then?

A. She was still having pain. I told her that she was probably going to need an arthroscopic operation. She had some swelling. I had discussed with her, but did not remove any fluid from her knee. Advised her to come back again, and we'd reevaluated making the decision whether or not she'd need surgery.

Q. Did there come a point and time she came back?

A. Yes.

Q. What happened?

A. She came back on the 18thsame month, November, and at that point the pain had persisted and we decided that we were going to go ahead with the orthoscopic procedure.

Q. And did there come a point and time you performed an arthroscopic procedure on Ms. Luna?

A. Yes.

Q. And what's the purpose of that arthroscopic surgery?

A. Well, an arthroscopic operation -- should I describe the procedure.

Q. You know what, let me show you the board which are now in evidence. You can use the board to explain to the jury Ms. Luna's preoperative condition and surgery and postoperative position. You can do it in a sitting or standing position, however you feel comfortable?

A. I'll stand up.

Q. Okay.

A. I'm going to use this model.
Q. If you like to use the model. Is that a model?
A. This is the model of the knee joint similar to that one.
Q. Is that a fair and accurate depiction of a knee joint?
A. This is a representative mock of knee joint without muscle and skin, just bones.
Q. Would that help you explain to the jury the nature of the injuries?
A. I think it will.
Q. Please proceed. First of all describe to us the anatomy of the knee?
A. That's what I'm going to do. So this is a model of a knee joint. This is the model of what would be my right knee like that, so this is the thigh bone. I don't know if you can see it. Okay, thigh bone, leg bone.
Q. Doctor, maybe you want to come out in the front now so everybody can see.
A. Thigh bone, leg bone and the joints is in between, right and this is the knee cap. So it's all covered with muscle and skin. If you took that away, the skeleton, that is the knee cap called the patella. So I'm going to bend the knee and I'm going to - I'm going to turn up the knee cap, so you reach down and turn your knee cap out.

Now you're looking at the joint. The joint is the blue. That's what you're looking at in the joint. Now I want to describe the joints to you. What -- it's a like normal. The best way I can describe it is to say the blue surface, which is the joint surface, it's the surface of the bone. It's covered with what we call articular cartilage. It has like a white thin covering that look like an egg shell, but the egg shell would be slimy. One best way I can describe what that looks like is to tell you that if you ever eat a piece of chicken, break the joint up and see that white, that's a normal joint. Okay. So, you're looking at the blue, that's a normal joint, and these cushions, these pads look like half a bone. That's what's called meniscus, and some people refer to it as cartilage and you have the medial. One inside of the knee and the lateral one on the outside of the knee.

Q. Doctor could you just show the jury where the lateral meniscus is in relationship to the knee?

A. It's on the outside. The lateral is on the outside, medial is in the inside, and those cushions serve for pads. The have different functions, but they serve as spacers, cushions, is shock absorbers. So when you move your knee up and down, there is cushion there and it keeps the bones apart. That's what the function is, and some other functions to serve as lubrication. Basically that's what those do. And this surface should be nice and smooth and clean and have no dents, or bruises on them. So that's the anatomy and then you have the surface of the knee cap, and where the knee cap also rubs here.

Q. Doctor, can I ask you a question? What's the importance of this cartilage meniscus between the two bones?

A. It's a cushion shock absorber and also serve as a lubricator and spacer. If there is nothing there these two bones come together.

Q. What does that mean?

A. Means you're going to have pain, usually represents an arthritic knee.

Q. What is arthritis?

A. Arthritis is, instead of having that nice smooth surface, the white glistening surface, it's more like copper lined rough surface, not smooth, and some areas almost looks like a strand of spaghetti, and it's rough, and instead of smooth pavement, it's rough. When you have an uneven surface, the joint doesn't work properly. So with arthroscopic surgery, what we do is put a tiny telescope ,it's smaller than that this. It has a camera. It goes into a tiny puncture as big as a finger nail.

Now it's in the joint attached to a light source and you look up and see the t.v. screen monitor. So you see the joint. You visualize the entire joint with the endoscope. You decide what you want to do, put the other instrument on the other side of the knee, and that's the issue, the work you're going to do, whether shave it, or clean it. That's what arthroscopic surgery is. Then you remove these and put stitches in. That's basically what arthroscopic surgery is.

Q. Could you use the board to describe the pre-surgery

condition.

THE COURT: Doctor, when you pick up the diagram, identify it on the top right.

THE WITNESS: This is number 8, Plaintiff's Exhibit Number 8.

THE COURT: Fine.

A. So, this is a diagram in color of what I just showed you. I don't know if you all see it, so, here is the knee cap. I told you about the thigh bone, leg bone down here, and the menisci in here sticking in here, and in this particular diagram, mine was blue, this I guess is purple and this is the knee cap and the knee cap tendon, and here you can see the meniscus. The half a donut I showed you before on that model. These are ligaments.

Now, hears what the arthritis looks like. You see this area here where the joint is uneven and red and angry looking, so instead of being nice and smooth, and this is red only because this is the color on the diagram. Again I told you in real life, it's a white substance, and this is angry looking. Looks like someone came along and was taking a shot at it with a hammer, and this is a tear of the meniscus. Hear's the meniscus, the cartilage, that cushion I showed you, and here's the tear.

Now, these diagrams aren't specifically exactly what Ms. Luna's looked like because her problem with the arthritis was more in this area here, and the tear was in this area, but gives you a fairly good idea what things look like instead of being nice and clean, they are red and angry and torn.

Hear's another view of the meniscus tear. Only in her case the tear is not here, it's -- I'm going to mark this.

MR. GUNZBURG: Go ahead.

THE WITNESS: In her case the tear is here, like this.

THE COURT: Okay.

THE WITNESS: Okay, so, this is what's torn in her case and this is where the arthritis is, in that area where it's all rough and angry. So torn meniscus, the rough area, also in this area here there are also arthritic changes.

THE COURT: Are you having trouble seeing?
THE JURORS: Just a little bit.

Q. Doctor, when you're referring to the torn meniscus and you're drawing that area on the pad, if you will, assuming that Ms. Luna didn't have the surgery, what would that mean; what kind of condition would she be in if she didn't have it?

A. The tear gets worse. It keeps shredding, the meniscus tear. When it tears it doesn't heal, doesn't have enough blood supply. Never does, in mine, in yours, in about 90 percent, maybe 85 percent it wouldn't heal because it doesn't have good blood supply. The blood supply comes in from the edge and that's only a very small percentage. In older people, when I say older, once you get pass teenage, most don't heal. So when you have a tear in your 30's 40's, 50's, maybe older than that, they don't heal, and they grin because the surface is uneven. That surface I showed you should be smooth. This is grinding on this surface because they are close together which is not necessarily easy to understand. It's not a big space. This looks like a big space, even on the model. I showed you, its not. It's small. When we put the endoscope, you have to push it in. You see the surface close together. If you have a bad spot, then that bad spot is going to rub. I like to compare it to if you put a stone in a machine, or cylinder and that cylinder is going up and down and there is a stone in there, it's going to irritate the wall of the cylinder and eventually it's going to break down. So that's what the tear is, and that's what the arthritis looks like.

Q. What about in the third diagram on the right?

A. This one?

Q. Yes.

A. Well, this is showing the knee cap tendon, which was not involved and this is the knee cap itself. What this is referring to is what's called sinovitis.

Q. What does that mean?

A. Inside the joint, the lining of the joints, of these joints all have a lining. It's called the sinovium. Sinovium is a tissue that's soft and enables the joints to align. Ordinarily it's thin. It's almost like comparing the lining to let's say aluminum foil. It's thin. The joints glide when it's inflamed,

irritated. It's boggy like foam. It's boggy and causes pain. That's sinovitis.

So when Ms. Luna had surgery it was necessary to remove the part of the cartilage that was torn, to remove some of the sinovium, the inflamed tissue and also do what's called chondroplasty.

Q. We have another board so you will be able to go to the next one and indicate to the court reporter --

A. This is Exhibit Number 9. So this shows you what I was talking about before. Remember I showed you the arthroscopy and here's the arthroscopy. Hear's things to go clean up. Sometimes you can put a third one in, but usually it's two and that's what arthroscopic surgery is.

Now in cleaning up the arthritis, smoothing it out and removing some of that rough tissue, it's a shaver that cleans the arthritis. In her case I told you a more accurate depiction would be involved in this area which is the weight bearer, so that has to be smoothed up and cleaned out with the shaver.

Also here, this is the tear. Remember I told you the tear is in here. That has to be removed. Not shaved but has to be removed. Sometimes you shave it too, but has to be remove so what you wind up is with a meniscus, or cartilage that is much smaller than she started out with. But all of that will to be removed.

Q. What do you put in it's place?

A. Nothing.

Q. So it's empty?

A. Empty. Now, to be more accurate, there are, I wouldn't say experimental, but there are cases being done now, selected cases where cadaver graphs are put in there, but would be usually in someone of Ms. Luna's age, but it is in some cases. To answer your question they can put cadaver graphs but very rarely done. You have to remove the part torn. You can't repair it. It wouldn't heal. You can put stitches in. It's like putting stitches if you have bad diabetes in your foot, you have bad circulation. That's why sores won't heal. If you put stitches where there is no circulation, it won't heal. That's why when we repair, we remove the part that's torn.

Q. Can I ask you something? What prevents further deterioration of the meniscus if you're removing that piece?

A. Sometimes it doesn't cure it. Sometimes it continuing to tear. Sometimes the entire thing can be torn, so you have to remove as little -- as little as you can and still maintain the structural anatomy because you like to maintain it because it's serving as a cushion, even though that cushion is going to be smaller, it will still function, but less so.

Q. Can I ask you a question. When you remove that large piece of meniscus, is there a portion of the femur and tibia that comes together?

A. That's what can happen, yes. Now because now the joint space, now these surfaces are not being protected by the entire cartilage, so they start to get a narrowing of the joint space. That's what arthritis is.

Q. What does the patient sense?

A. Pain, because it's almost like surfaces are kissing. Once they start to touch and rub against each other, then you experience pain, And you can have a catching sensation. You can have clicking, you can have pain -- you can have this pain standing.

Q. Anything else on the board you want to introduce? And what about the last board in terms of post-operative condition, what did she actually look like after the surgery?

A. Well, after the surgery --

THE COURT: Doctor, this is board number 10 we are talking about now?

THE WITNESS: Number 10.

THE COURT: Okay.

A. So, after the surgery, and again, in this diagram in these drawings it always refers to this area, but in fact this area here, so it's smoothed out. It's cleaned up. Remember in this one was all red and angry? Well, it's been smoothed out. It's almost like taking -- mowing the lawn. You smooth it, you can't cure it. You can't cure arthritis by making it go away. You can help the symptoms by smoothing it out. That's what we call grade, or rough area, we smooth it out and that's call chondroplasty and that's what she had done here.

And here where the tear was, a significant part was

removed. And the lining, the sinovium, that was also cleaned up. You don't remove the entire sinovium. You remove the swollen area that's painful to you.

Q. Now doctor, you mentioned arthritis?

A. Excuse me. I'm just -- Excuse me.

Q. Sorry.

A. This is -- this was a little hard to see. Here's the meniscus again you're talking about. Here's the normal one. This is the normal half of a donut and you know, we have -- we have a significant amount of the meniscus, or cartilage to make it smoother.

Q. Doctor, what I was going to ask you was with regard to arthritis, did Ms. Luna complain to you?

A. Excuse me. Are we finished with this?

Q. Yes, you can sit down.

Did Ms. Luna complain to you when she first came to you that she had any problems with her right knee before this incident?

A. No.

Q. And is it possible that someone can have arthritis and not know it?

A. Yes.

Q. And if someone was -- have you ever heard the term asymptomatic, someone who never had a problem?

A. Yes.

Q. What does that mean?

A. Asymptomatic means no symptoms. So, not complaining of anything. Nothing hurts.

Q. And is it possible that someone can have arthritis and not know about it and have an accident that all of a sudden make that condition symptomatic?

A. Yes.

Q. Do you know if that's the type of situation that happened here to Ms. Luna in connection with her right knee arthritis?

A. I think so.

Q. Now, doctor, I'm going to read for you a hypothetical question, and then I'm going to ask you to assume these facts in evidence and then ask you your opinion, okay?

A. Repeat that please.

Q. I'm going to ask you a hypothetical question, then I'm going to ask you your opinion?

A. Okay.

Q. I want you to assume the following facts are in evidence doctor that on October 25, 2008, at around 9:30, 10 o'clock, a woman boarded a Q44 New York City Transit Bus at Archer Avenue and Southern Boulevard in Jamaica, New York. She paid her fare and firmly take hold of the handrail with her right dominate hand when the bus operator suddenly, violently and without warning accelerate the bus ripping her hand from the railing and causing the woman to fall hard and rapidly on to her right knee.

According to the woman, she was in excruciating pain. She testified 10 out of 30, sharp, constant pain and was unable to get up. The bus operator stopped the bus and several good samaritans, including a former ex-police officer picked her up and placed her in a seat and that woman road home with her leg extended in front of her in pain, and when she arrived at the Parkchester stop, she limped off the bus, pass the bus operator down onto the sidewalk, and she limped home. And she took 40 minutes to get home, what would normally take two to three minutes. And when she got home, she elevated her right leg. She took Motrin, put some ice on her right knee to reduce the swelling and she claims that she was unable to sleep throughout the night and the next morning she took a taxi cab to Jacobi Hospital Emergency Room where she went to the ER and was treated by the staff.

She underwent an x-ray. They told her she had a joint effusion, swelling and tenderness. They wrapped her knee up in an ace bandage, issued her a cane to assist in ambulation and instructed her to take Motrin, and told her to see an orthopedic doctor. They gave her instructions on rest, ice compress and to elevator, and then discharged her.

Three days later when the pain did not improve, she received a referral from a fellow physician, Dr. Perez, to obtain a right knee MRI. She went to Doshi Diagnostic and underwent an MRI of her right knee. She met with the radiologist and the radiologist advise hear based on the MRI films which are

evidence, that she had a complex tear within the interior horn of the lateral meniscus and intra-substance tear of the medial collateral ligament complex at the level of the joint space of the medial meniscus, high grade chondromalacia in the patella. She had loose body joints within the supra-patella bursa, intraosseous contusion within the central and posterior portion of the lateral femoral condyle and adjacent portion of the tibial plateau, large retropatellar and suprapateller effusions, extensive soft tissue swelling, anterior to the patella and patellar tendon.

The woman took the MRI report to you, you met with her, you examined her and you indicated that she had swelling and pain and that she had grade 1 effusion of the right knee and limited strength of the right knee, 4 out of 5, as compared to the left, limited range of motion, medial joint line tenderness lateral joint line tenderness, positive McMurray's sign on the right knee, and she underwent physical therapy in an effort to avoid surgery, and she had the physical therapy and according to her, made it worse.

She stopped and she returned to your office, and on December 10th, she underwent arthroscopic surgery by you at Roosevelt Hospital and a partial arthroscopic lateral meniscectomy and femoral condyle and a partial synovectomy. She was discharged home with an ace bandages around her knee, a cane and pain medication and given a program of rehab and physical therapy. She testified it consisted of a variety of exercises which when she used the board which we have here, which indicated various exercises that she performed and she did massage, ultrasound, heat and cold. She was given a home exercise program and she complains that she was unable to resume her full-time position as a Pediatrician. She needed the help of an assistant, unable to handle the same patient load since the incident, and has to sit and take breaks due to right knee pain and according to your notes, post-operatively, the woman's prognosis was guarded, and you discuss possible future surgical intervention and supartz injections trial.

And she also complain she is unable to engage in her usually customary activities and her injuries have had an impact

on her quality of life as a Pediatrician and also in her ability to treat her patients and participate in dance classes and also that she is unable to do pilates.

Doctor, now I'm going to ask you your opinion. Do you have an opinion with a reasonable degree of medical certainty as to what caused Ms. Luna's right knee injuries.

A. Yes.

Q. And what's your opinion?

A. I think the fall and the contusion which is the bruise of her knee and the tear of her lateral meniscus caused her to have the symptoms, or the history that you described.

Q. And do you have an opinion as to – with a reasonable degree of medical certainty, as to Ms. Luna's current condition based on your medical chart?

MR. REYNOSO: Objection. May we approach?

THE COURT: Step up.

(Whereupon, there is a discussion held off the record at the bench among the Court, defense counsel and plaintiff's attorney.)

Q. Doctor, do you have an opinion with a reasonable degree of medical certainty as to whether Ms. Luna was unable to engage in her usual and customary activities for 90 out of 180 days immediately following her accident?

A. Yes, I did.

Q. What's your opinion?

A. That she was unable to do those things, usual things that you described.

Q. Why is that?

A. Because of the pain.

Q. Because of the pain?

A. Yes.

Q. Now, does – do you have an opinion with a reasonable degree of medical certainty as to Ms. Luna's prognosis?

A. Yes.

Q. And what is your opinion?

A. Well, to use a word that we use, I would say it's guarded, which means that it's not good. It's a little hard to say, but I would be concerned in the future. She may need

another operation, either arthroscopic surgery, or knee replacement.

Q. Why do you say that?

A. Because of the findings that I saw at the time of surgery, the arthritis that she has and the significant tear of the meniscus and the other things that I described in terms of what surgery was.

Q. Doctor, have you ever seen any patients that have similar conditions to Ms. Luna?

A. Yes.

Q. And the patients, based on your experience with patients, have you ever seen patients with similar conditions undergo knee replacements?

A. Yes.

Q. And what's the likelihood that Ms. Luna is going to need a knee replacement on her right knee in the future?

A. I think it's possible and as she gets older it becomes more likely.

Q. And when you say it's possible and more likely as she gets older, if I told you today she is 48 years old, could you give us an idea when you believe she would need knee replacement?

A. I didn't hear you.

Q. Could you tell us based on your experience and patients you've treated, when do you believe Ms. Luna will require knee replacement assuming she's 48 today?

MR. REYNOSO: Objection.

THE COURT: Sustained.

Q. Doctor, do you have an opinion with a reason degree of certainty base on your evaluation of Ms. Luna, when she will require knee replacement assuming she is 48 today?

A. Do I have an opinion?

Q. Yes.

A. Yes.

Q. What's your opinion?

A. I think it becomes more possible when she is approaching the age of 60.

Q. When someone age 60 undergoes knee replacement, how long does a knee replacement typically last?

A. There are different statistics about it. One would assume it would probably last up to maybe beyond 15 years. Anywhere from 12, 18 years. There are people that go a life time without another operation, but it's fair to tell a patient who is going to have a knee replacement they may need another one in their lifetime after anywhere from 12 to 15 years, average out 15 years ago like that.

Q. Is it fair to say if Ms. Luna is going to undergo knee replacement at age 60, she would probably need another one in her 70's?

A. It's certainly possible, yes.

Q. Now --

A. I'm sorry, well, again based on what I said, middle to late 70's, it varies. You can have knee replacements that's fine, and lasts 5 years. You can have knee replacements that's fine that lasts 20, 30 years. The numbers we used to tell people it's in the 15 year, 18 year range.

Q. What does it depend upon, the need to have knee replacements in the future?

A. Because different things happen. The component we call them, when you have a knee replacement, everything I showed you there is removed, so --

Q. Can I just stop you for a second. Could you show the jury how a knee replacement is actually done using the anatomically scale, the model?

A. So getting back to the model. Take that knee cap and in the knee replacement most of the time there are different ways to do knee replacements. The bone is cut here, so all of this goes. This is a cut and removed and the bone is cut here, so basically all the knee is gone. The joint, cut it out. Removed it. And now you're left with space, and in that space you put what are called components. So there is a new part here and those components are not metal. It's a different kind of alloy. Sometimes it's like a plastic, but it's artificial. So one goes in here, then you have a matching one that goes in here. So now you have it in here and also the knee caps. Now sometimes you can have a knee replacement and only one part can be removed. That's called a unilateral or uni.

Now you have a new knee. The arthritis is gone

because it's been removed. So new parts and those parts, the reason you might need another one, is those parts over time can start to wear because they are not – they are not what we have. It's artificial. So you have metal, the surfaces can fatigue and they can loosen and when that happens, then pain. So you get loosening or fatigue of the artificial surface, then you have pain. That's why people have another one and that's call a revision, which is a little harder to do than the original.

Q. Tell us how revision work?

A. Revision, you have to go take out what was put in, so take out the old parts and put in new parts. And because those old parts have been in there for a long time, sometimes the bone is not as strong. So technically it's a little hard to do and sometimes the results aren't as good.

Q. Doctor, do you have an opinion within a reasonable degree of medical certainty -- withdrawn.

When you undergo a knee replacement surgery, is that considered an out-patient procedure?

A. No.

Q. What kind of surgery is that?

A. That's a major operations and you're in the hospital for about three or four days.

Q. And –

A. And then there is a lot of rehab afterwards.

Q. When you say a lot of rehab; one, or two days?

A. No. You either, if you have enough help and assistance at home you can go home, but then you have to be able to get to a physical therapist and a lot of people, especially when we get older, doesn't have that kind of help around, so very often those people go to a rehabilitation facility which is a place where it's not a hospital, but it's a rehab facility and that's where you do your exercises and learn how to walk, first with a walker, then with a cane, and eventually get back to your life. That can take awhile.

Q. How long does it take a patient, say a 60 year old who has undergone a major surgery such as knee replacement of the right knee, to undergo physical therapy and regain their life back?

A. A matter of months, three months or so.

Q. Okay, now, Doctor, do you have an opinion with a reasonable degree of certainty as to whether Ms. Luna has a permanent disability?

A. Yes.

Q. What is your opinion?

A. I think she has a permanent partial disability.

Q. Is that a permanent partial disability to her right knee?

A. To her right knee.
Q. Will Ms. Luna's right knee ever be normal again?
A. No.

MR. GUNZBURG: I have no further questions.
THE COURT: Thank you. Step up for one second.
(Whereupon, there is a discussion held off the record at the bench among the Court, defense counsel and plaintiff's attorney.)
THE COURT: Keeping with my promise to you, we will take a five minute break. Please don't discuss this case among yourselves, or with anyone else. Keep an opened mind. You can use the facilities if you like. We'll call you back in five minutes.
(Whereupon, the jury exits the courtroom.)
COURT OFFICER: All rise. Jury entering.
(Whereupon, the jury enters the courtroom.)
THE COURT: Welcome back. Doctor sit. Make yourself comfortable.
Mr. Reynoso, cross examination.
Ms. Luna, I will remind you you're still under oath.

CROSS-EXAMINATION
BY MR. REYNOSO:

Q. How you doing, doctor?
A. Okay.
Q. All right. All right, now, you were asked at the beginning of counsel's direct examination whether you testified at times at trials and you said yes, correct?
A. Correct.
Q. Okay, and you said you testified for both defense attorneys and plaintiff's attorneys, correct?
A. Correct.
Q. Could you estimate in percentage as to what percentage you testified for plaintiff and what percentage for defendant?
A. It's hard to do. I --
Q. Rough estimate?
A. Well, in malpractice cases, it's usually for the defense and in the civil cases I'd say half and half.

Q. And now how often, or how many times a year do you testify?
A. Not often.
Q. And how long have you been testifying, for how many years?
A. Excuse me.
Q. For how many years have you been doing this?
A. Well, since I have been in practice just about.
Q. Okay, about how many years is that? How long have you been in practice?
A. I started practice in 1970.
Q. You say not often. Once or twice a year, are no?
A. Yes, that's about it.
Q. Now, you have your own patient load right now, or no?
A. Yes.
Q. And what percentage of those patients have personal injury cases?
A. A significant number.
Q. Significant number?
A. Yes.
Q. Do you get referrals from lawyers for patients?
A. Not often, no.
Q. Now, Mr. Gunzburg asked you whether you met him before today and you said no, you haven't, correct?
A. No.
Q. Okay. Actually you were asked a series of questions about how patients who have arthroscopic surgery react, and what type of treatment they may or may not need in the future, correct?
A. Yes.
Q. And during the break, A-Rod came up and you worked for the Yankees, right?
A. I work for the Yankees.
Q. He had arthroscopic surgery last year,

right?

A. Yes. I'm going to -- there are certain --

THE COURT: No one is asking you to break any privileges, doctor.

THE WITNESS: There is HIPAA.

Q. All I'm saying from -- all I'm saying, on the news he was, after the surgery, he was back playing in about a month, isn't that correct?

A. Four to six weeks. I don't remember exactly. Five weeks, to a month, four and a half weeks, to a month.

Q. So about a month he was back to playing baseball, playing third base?

A. Correct.

Q. And his job requires him to run and jump, correct?

A. Yes.

Q. Now going back, in your chart do you have a report dated March 9, 2010? I have a copy of your report. Could you see there?

A. A report of what?

MR. REYNOSO: Can I show the doctor a copy?

THE COURT: You may.

Q. Do you have this report in your chart. It's more like a summary?

A. Oh, this is a narrative. Yes, okay, yes.

Q. You have that? Okay, great.

Okay, now we have the same narrative March 9th, 2010, correct?

A. Correct.

Q. And who do you address in these narratives?

A. Mr. Gunzburg.

Q. Although you never met him prior to today you have corresponded with him, is that fair to say?

A. Yes. He had asked for a narrative. He requested a narrative report about his client, my patient. This is a letter to him.

Q. He called you up and asked you for a report?

A. I didn't speak to him directly. He spoke to my secretary. There is a routine. A lawyer would call and say they want a narrative report. My secretary would tell me, I --

Q. I get it. It's fine.

A. But there is no other correspondence between me and him.

Q. You charge for this?

A. Yes.

Q. About how much do you charge?

A. You know, I'm not sure.

Q. Typically, any idea, roughly?

A. It might be anywhere from $500 to $1000. I'm not sure.

Q. Okay. Now, this report closes and then I have sort of addendums to the report, another separate letter. Do you see that?

A. A separate letter? No.

Q. Okay.

MR. REYNOSO: May I approach?

THE COURT: You may.

MR. GUNZBURG: I object if he hasn't seen it, Your Honor.

MR. REYNOSO: We can mark it, and I can ask questions about it now.

MR. GUNZBURG: Can I see it?

THE COURT: Let the lawyer see it. Do we need to mark this counsel, or, are we okay?

MR. GUNZBURG: You mean mark it for evidence, or identification?

THE COURT: For identification purpose.

MR. GUNZBURG: I have no objection. You can put the whole report in evidence. If he is going to use it for the doctor let him put the whole report in.

MR. REYNOSO: Most of it is in his chart. Just one letter.

THE COURT: Show him the letter.

Q. Just read it to yourself.
Okay, now, is this a letter signed by you?
A. Yes.
Q. Is it your report you also mailed to Mr. Gunzburg?
A. Yes.
Q. And it's also dated March 9, 2010?
A. I didn't hear that.
Q. It's also dated March 9th?
A. That's right.
Q. Okay, and it's an addendum to your original narrative of March 9th, is that correct?
A. Correct.
Q. Okay, going back to the original narrative, page 1. You do have a copy of it. In your -- in the very -- at the end of the second to last paragraph, it says --
Well, you know what, turn to page 3 and the last paragraph.
A. Page 3 of the March 9th letter?
Q. Yes.
A. Last paragraph?
Q. Yes, last full paragraph. Take a look again at the second to last sentence. Start with, "I recommended".
A. Second to last sentence.
Q. "I recommended".
A. Yes.
Q. Just read that paragraph?
A. You want me to read it?
Q. Yes, out loud.
MR. GUNZBURG: Objection. Is it in evidence, Your Honor? Oh, it's his chart.
THE COURT: Go ahead, doctor. You may read it.
THE WITNESS: You want me to read where it starts "I recommended."?
Q. Yes, sir.
A. "I recommended at that time that she

continue on exercise prodigal, and I will see her again if necessary. The possibility of future surgical intervention was discussed. I also discussed the possibility of supartz injection trial, which I described to her."

Q. Then you added -- that's how you concluded that narrative. Then you added this addendum. Do you know why you added an addendum to your report in addition to your report?

A. No, I don't remember.

Q. Could you see the changes that you made in this --

MR. REYNOSO: You know, Judge, I'd like to enter this addendum into evidence since it's not part of his charts?

THE COURT: You mark it for identification first. Defendant's A.

MR. GUNZBURG: Your Honor, I'll consent to putting that narrative report and addendum in so the jury can see the entire report.

THE COURT: Hold on. We don't need any discussion yet. Mark that Defendant's A, that letter, mark that for ID purposes now.

Any objection to have the addendum marked in evidence?

MR. GUNZBURG: Yes, just the addendum itself, yes sir.

THE COURT: Hold on, don't -- step up.

(Whereupon, there is a discussion held off the record at the bench among the Court, defense counsel and plaintiff's attorney.)

THE COURT: On consent of the parties, the narrative and letter of March 9th will be admit in evidence.

Is that your understanding Mr. Gunzburg?

MR. GUNZBURG: Yes.

THE COURT: Is that your understanding Mr.Reynoso?

MR. REYNOSO: Yes.

THE COURT: Defendant's A will be marked in evidence, including the narrative letter and addendum as the doctor called it. And that will be Defendant's A, in evidence on consent.

(Whereupon, the item previously marked for identification is marked in evidence as Defendants Exhibit A, in evidence.)

THE COURT: If necessary we will redact what has to be if that's required based upon that form, redact legal terms to replace certain things that's not in evidence. We will take care of that later.

Sometimes addresses and numbers are there that shouldn't be there. I don't know. I haven't seen it.

Continue, Mr. Reynoso.

Q. Now doctor, you say you don't know why you issued this addendum, is that right?

A. At this time I have no recollection.

Q. Now you seem to expand on your conclusion, I will say for the future here.

Could you read what you concluded plaintiff may need as appose to how you concluded in the other report?

A. Do you want me to read it? What was your question?

Q. What was your conclusion here, your recommendation?

A. I'm sorry. You want me to read the whole thing?

Q. Is it the whole conclusion? Is there a conclusion there, or no? Maybe it's the wrong word. What's your prognosis there?

A. Well, I will read the sentence. Maybe that will satisfy you.

"There is a possibility that in the future surgical intervention may be necessary. This will

case?

A. I wouldn't know except that she didn't relate in her history anything that would relate to that.

In other words she didn't complain about her knee prior to the accident.

Q. Now, you said something very interesting. You said many things, interesting things I noted during your testimony.

You said that part of the meniscus that Ms. Luna had a problem with on her right knee was a weight bearing part, is that what you said?

A. I did.

Q. Now does a person's size and height have any effect, or importance with respect to any potential problems with their knee, or their meniscus?

A. It can. But it's difficult to generalize. People who are over weight can have a higher incident of problems with their knees. Then there are a lot of thin people who have knee problems too. But in answer to your question, size can be a problem in terms of people who are over weight.

Q. Now you mentioned the word arthritis several times in your testimony. What is arthritis?

A. It's an inflammation of the joint. I tried to show it on the diagram where the surface of the joint becomes inflamed, irritated, not smooth anymore, but rather rough and irritated.

Q. I grew up thinking of arthritis as something you get when you get a little older. Is that something you get over time due to wear and tear?

A. You can get arthritis because of age, but you can get arthritis because of injury and wear and tear too, as you mentioned.

Q. Okay, now obviously in this case you reviewed the MRI taken of Ms. Luna's right knee, correct?

A. Correct.

Q. Did you see what are called degenerative

changes in that MRI film?

A. Yes.

Q. What are degenerative changes?

A. Basically it's another way of saying arthritis. In other words, the joint surface isn't smooth. There are little bumps and ridges. We call those osteophytes, or bone spurs.

Q. If it's degenerative, does that mean it happens over time?

A. Yes.

Q. So it's not a degenerative condition, it's not one that occurs one occurrence, it's something that occurs over the years, wear and tear?

A. Degenerative change occurs over a period of time. The insult to the knee in terms of bruises and contusion occurs at the time of the injury.

Q. Now there are records in evidence from Bronx Physical Therapy, and the last time that plaintiff went to physical therapy was on February 3rd, 2009, you're aware of that, correct?

A. I can't recall now, no.

Q. When is the last time -- withdrawn.

When did your regular treatment of plaintiff cease; when did it end, your regular treatment?

A. Aside from the last time when was the last time I saw her?

Q. That's not what I'm asking you?

THE COURT: Mr. Reynoso, rephrase that question.

MR. REYNOSO: Yes sir.

Q. According to the narrative that we have in evidence here, March 9, 2010, you saw Ms. Luna on February 3rd, 2009 and then you saw her again on December 8, 2009, correct?

A. Yes.

Q. And had you continuously treated the plaintiff since 2009?

A. I didn't hear you.

Q. Have you continuously regularly treated

the plaintiff since 2009?

A. No.

Q. And why not?

A. I haven't seen her.

Q. Is it because she has not gone back to your office, is it your call? I'm asking why?

A. No, she hasn't returned.

Q. Do you know why you saw her in February 2009, and didn't see her for another 10 months thereafter? Why was there a ten month gap?

A. It happens sometimes. Patients don't come back all the time.

Q. Do you know why her physical therapy only lasted three months, then no more therapy after that?

A. Three months is a reasonable time for a rehab protocol following the surgery that she had.

Q. Could you --

A. And -- excuse me. And sometimes, I don't know about her case, but sometimes insurance companies won't pay for it.

MR. REYNOSO: Move to strike. That's not the testimony.

THE COURT: We are going to strike that portion of the response.

Next question.

Q. When you examined her that last time in 2009, what were your findings in terms of range of motion tests you took?

A. 2009? Tell me the date. What was the date again?

Q. Pardon me?

A. Date.

Q. On March 9th report narrative says you saw her on December 8, 2009?

THE COURT: Wait, wait, wait, wait. The March 9, 2010 report?

MR. REYNOSO: Exactly.

THE COURT: You said 2009.

Q. 2010 report, which talks about the December

'09 visit, correct?

A. No. You want me to refer to the December 2009, is it?

Q. Yes. What were your findings that day?

A. I don't have a December -- I have December, 2008.

Q. Let me show you.

MR. REYNOSO: May I, Judge.

THE COURT: You may.

A. I can read it to you, I put in that narrative. For some reason that visit is not -- the December -- I can't find it.

Q. That visit is in the narrative, but not in your regular chart?

A. I don't know why it's not here.

Q. Could be she was sent to you at the time, by your attorney, it's just an attorney referral?

A. And no matter why she came -- here it is. Here's February 2009.

Q. Just read from your narrative. That's find. Tell us your findings according to your narrative?

A. Okay. In the narrative, 12/8/09?

Q. Yes, sir.

A. You want me to read it.

Q. Your findings, yes.

A. Okay. She stated that she had occasional discomfort when rising from a sitting position. Her examination at that time revealed that the portal sites, incision sites, were well healed. Range of motion was 0-140, 0 degrees to 140 degrees. Right knee was stable to valgus and varus stress. Describe certain tests we do; minimal tenderness was noted over the anterior of the knee. I recommended at that time she continue an exercise protocol and I will see her again if necessary. The possibility of future surgical intervention was discussed and also discussed the possibility of supartz injection trial.

Q. You stated the right knee was stable to Valgus?

A. And varus.

Q. And varus test. What does that mean?

A. A stress test. When we stress the knee and push on it and stretch it, if it's stable it's not going to open up. You can feel instability. It would be valgus varus, the angle you move the knee if it would be varus.

Q. So this was good? It was stable?

A. Yes.

Q. And you said lack -- pivot shift anterior drawer, posterior drawer were negative. What are those?

A. Test we do manipulating the knee, seeing if it's unstable and you can feel it in different positions; forward, backward, this way, that way, if a little wobbly, it was loose.

Q. So they weren't unstable, they were good?

A. Correct.

Q. That was December 2000 --

A. That's what we referred to here in the narrative. Unfortunately I don't see it here in the chart, but if I referred to it, it's there.

Q. Now, you were asked on direct whether you had an opinion as to whether or not Ms. Luna could perform her usual and customary activities the first -- actually 90 days out of the first 180 days following the accident, and you said within a reasonable degree of certainty, yes, that's the case. Do you remember that testimony?

A. Yes.

Q. Now, where in your chart did you tell her that she should not go to work? Where did you say you shouldn't work because of her injury?

A. It's not here.

Q. Why not?

A. May not have told her.

Q. It's an important thing if you felt that

way, you would have wrote it down, correct?

A. Might have.

Q. How do you know now whether she was able to do the first six months following her accident at that time. You didn't write it down. How do you know that now?

A. I think from what she told me when she came back to visit me after surgery. Patients who have arthroscopic surgery often found asymptomatic go back to work and are able to do certain things even though they have pain, but not able to do other things that they did, such as; sports, or gym, or things like that. It's a mixed bag. Sometimes people go back to work and are still in pain. Some people don't.

Q. Has Ms. Luna ever complained to you about her other knee?

A. No, not that I can recall.

Q. You also testified the cause of her right knee injuries were this accident, correct, you testified to that?

A. Yes.

Q. Okay, have you ever seen Ms. Luna before she came to you on November 2008?

A. No.

Q. And now you've told us you did see the degenerative change in existence prior to the surgery, you saw it on the MRI, saw it in the x-rays?

A. Prior.

Q. The degenerative changes that you saw on the MRI and on the x-rays, were those changes there when, you know, at -- doctor were those there from before this accident?

MR. GUNZBURG: I'm just objecting. He's talking about two different things, x-rays and talking about the MRI. Those are two different things.

THE COURT: He will rephrase it.

MR. REYNOSO: I will rephrase.

Q. We talked about earlier the MRI and you said

that you did see the degenerative changes on the MRI films, correct?

A. Yes.

Q. These degenerative changes, were those changes already there in Ms. Luna before this accident from your experience and knowledge and expertise as an Orthopedist?

A. Yes.

Q. Did you see her x-rays?

A. Yes.

Q. Okay, did they show degenerative changes as well?

A. I'm going to refer to this.

Q. That's fine.

THE COURT: Off the record.

(Whereupon a discussion was held off the record.)

A. Yes. Your question was did I see the x-rays?

Q. Yes.

A. Yes.

Q. Did you see the actual x-rays, or just the report?

A. No, the x-rays.

Q. And they also showed degenerative changes, correct?

A. That's correct.

Q. And these same changes were reflected in the MRI films?

A. Can't say the films, it would be a different procedure, but consistent with, yes.

Q. And those same changes were in existence before this accident, correct.

A. Correct.

Q. That being the case, how do you know that her injuries since she already had degenerative changes in her knee, caused by the accident weren't there before the accident; how do you know that?

A. Okay, so it's my experience when you have

a knee with degenerative changes, or one might say, early arthritis, a lot of people are walking around with arthritis in their knee. A lot of people in this room might have arthritic knees and don't know it because it does not hurt. Maybe sometimes you get up in the morning, it's stiff and you don't know it, but it's there. You have to have an MRI for no reason, but you have no change. It may show some arthritic change, especially as we get a little older.

Now when you have a significant injury, a blow to the knee, direct blow, contusion, such as having a fall, then the bone gets bruised, that shows on the MRI. There is bleeding inside the bone. Then it's like filling up a glass with water. It's okay until it fills over the top. It aggravates the knee.

Now if you had a problem before, but now because of the direct blow and the tear of the meniscus, which in all probability was not there before, then you have the combination of the pain and the arthritis, whereas before, you just had arthritis.

Q. Time is of the essence. Let me ask you this. You said in your life as a doctor, you performed thousands of surgeries, correct?

A. Correct.

Q. And thousands of arthroscopic surgery?

A. Thousands, yes.

Q. And would it be hundreds, or also thousands of knee surgeries, arthroscopic surgery?

A. Arthroscopic knee surgeries, thousands.

Q. Please, if you can give me a rough estimate, what percentage of those people you performed arthroscopic surgeries, what percentage of those people have gotten knee replacement subsequent thereto?

A. That's hard to say.

Q. Is it most of them, some of them?

A. No, some, not most.

Q. The majority or less than 25 percent?
A. It's an age factor here, so.
Q. Then look at people in the age range of Ms. Luna?
A. What I'm trying to explain to you and the jury is that if I operate on somebody today, and they are 45 years old, then in the future they might need a knee replacement, but we don't know yet. If I did somebody 35 years ago, if that person I did was one of those thousands that I did 30 years ago, then they would be more likely today to need knee replacement. So the word would be significant. A significant number of people who have arthroscopic surgery as they get older wind up needing knee replacement because that's space, because you removed that meniscus and taking that cushion away, the space starts to get smaller and smaller. The bone starts getting closer and closer and eventually become arthritic in the time span here.
Q. Would you agree less than 25 percent?
A. No, I wouldn't agree.
Q. Give us number?
A. I would say more than 10 percent, and I would say again, it relates to the age because if you do somebody who's 20, then, that may not happen until they are 60. If you do somebody who is 40 or 50, it may happen within a short period of time.
Q. You talked about 30 years ago. I would guess, correct me if I'm wrong, that arthroscopic surgery is more sophisticated than it was 30 years ago, or same thing?
A. 30 years ago takes us into the 80's.
Q. Yes
A. Arthroscopic surgery became something people were doing in the 80's. The principals are about the same.
Q. You referred to knee replacement surgery as major surgery. Do you remember that?
A. Correct.

Q. And you would be in the hospital about four days, and it takes you three months to recover after the surgery, you said that?

A. Yes.

Q. Arthroscopic surgery is you go in the morning and you're released that same afternoon, or evening, right?

A. That's right.

Q. Would you consider that major surgery, or minor surgery?

A. If the Judge doesn't mind, this is not a wise crack, but there is an old expression, "There is no minor surgery, only minor surgeons. If it's your knee and you have anesthetic anesthesia, it's major surgery. In comparing it, knee replacement is a much bigger operations, but a arthroscopic knee procedure is a major procedure. The fact you go in and out the same day doesn't make it inconsequential.

Q. That's fine. Compared to the knee replacement, it's not major surgery?

A. Knee replacement is a much bigger deal.

THE COURT: Mr. Gunzburg, remember, no matter how much time you take, he is going to take the same time. We will have to bring him back.

REDIRECT EXAMINATION
BY MR. GUNZBURG:

Q. Doctor, do you recall the difference between New York Yankee A-Rod and the Pediatrician, Ms. Luna?

A. If it's all right, lets take A-Rod out of the equation because there are certain -- lets just say athletes.

Yes, athletes than any person in their 40's or 50's or younger, the athletes are well conditioned and that person probably doesn't have arthritic changes in the knee, so the injury to the knee, the ball player, or football player land on his knee, tears his meniscus is probably not aggravating the previous arthritis, which in this case I think happened.

So the answer is there is a difference. There is a big difference also in the ability to rehabilitate. Their job is to just get better. They are usually in very terrific condition. They are not overweight, a lot of conditions, but it's the same operation. But that's where it ends in terms of the two people. If I were to operate on anybody in this room, including myself, then it wouldn't be comparable to operating on a 26 year old professional athlete in terms of how they are going to rehab and get better soon.

Q. Okay, counsel had a lot of questions with regard to this addendum to your report. Does the addendum reflect your opinion in connection with this case?

A. No, it doesn't.

Q. I'm saying is that part of your -- is that part of your report, the addendum, the narrative report?

A. It's part of the report. I don't know why it's not on the chart. It was part of the narrative.

Q. Part of the narrative report?

A. Yes.

Q. It's not a change of the report, it's part of the report?

A. Yes.

Q. Also counsel asked you about this degenerative change versus arthritis. And does degenerative changes also apply to what we discussed before about a patient being asymptomatic prior to having trauma?

A. Yes. You can have degenerative changes in your knee and feel fine, feel perfect. And then for some reason, including an accident, it might flair up.

Q. Now, after defendant's, all his questions that he just finished asking you, do you have a change to any of the opinions that you have made with regard to Ms. Luna having a permanent and partial disability, the causation of the accident and her position being guarded and she requiring future surgery?
A. I don't have a different opinion if that's what you're asking. Only thing I would add that I didn't explain before was that, stickily women for some reason don't do as well when they tear their lateral meniscus, which is what she tore. That's just another issue.

In other words, if you take any woman who's lets say past 30, or 40, after an arthroscopic procedure, take part of that lateral, or outside meniscus, part of that out, they don't seem to do as well as other people for some reason.

Q. That's based -- Is that base on your experience, you have seen that?

A. Not just my experience, it's a generally accepted fact.

MR. GUNZBURG: I have no further questions.
THE COURT: Anything else Mr. Reynoso?

RECROSS EXAMINATION
BY MR. REYNOSO:

Q. You talked about people in general and recovery and athletes. Any reason why her left knee healed after arthroscopic surgery completely and had no problems and may have problems with the right knee in the future and not left knee?

A. I never x-rayed, or did an MRI of her left knee. I don't know what the surgery was. Sometimes you have arthroscopic surgery and you don't removed anything, or maybe it can be a tiny little tear, so I can't comment on her. I didn't do the surgery.

Q. Didn't the right knee have arthroscopic? Since the right knee surgery have you done an MRI?

A. Since she had the surgery?

Q. Yes.

A. I don't think so.

Q. So how do you know what's going on in there right now?

A. How do I know what's going on?

Q. Yes. You haven't looked in there with a test?

A. I don't have a reason to look in there with a

arthroscope.

Q. I'm talking about an MRI?

A. If I were to go do another MRI with the knee, it would be with the idea she now today needs another operations right now.

Q. Because she doesn't, you have not had an MRI?

A. I haven't had a reason to do it because I'm not thinking about operating on her now. It's future.

MR. REYNOSO: Fair enough. Thank you.

THE WITNESS: Just to, about the athlete, you know, normal people can recover quickly. If I operate on your knee and you don't play ball, you can be fine. It's different from what the professional ball player can do and the average person.

MR. REYNOSO: I wasn't asking you about that. Thank you very much.

THE COURT: Anything else Mr. Gunzburg?

MR. GUNZBURG: I have no further questions.

THE COURT: Doctor, you may step down.

Thank you.

Ladies and gentlemen of the jury, you have heard everything today. Tomorrow, please, 9:45. We have medical testimony coming in tomorrow in the afternoon. Do not discuss the case among yourselves or with anyone else. I think it's going to rain so stay dry. See you tomorrow.

(Whereupon, court recessed and the case adjourned to April 27, 2012.

THE COURT: Mr. Gunzburg, please call your next witness.

MR. GUNZBURG: Call Dr. Stuart Kahn to the stand.

COURT OFFICER: Sir, remain standing. Raise your right hand.

Do you swear or affirm that the testimony you are about to give shall be the truth, the whole truth and nothing but the truth so help you God?

THE WITNESS: I do.

COURT OFFICER: State your name for the