IN THE CIRCUIT COURT FOR TALBOT COUNTY

STATE OF MARYLAND

	:	
Plaintiff	:	
v.	:	
M.D.	:	20-C-05-005540 MM
and	:	
, LLC.	:	
Defendants	:	

****

Deposition of , M.D., taken on June 30, 2006, at 4:10 p.m. at the Offices of , before Daphne S. Hurley, Registered Professional Reporter and Notary Public.

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1 APPEARANCES:
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7 On behalf of Plaintiff
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14 On behalf of Defendant M.D.
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1 PROCEEDINGS
2 Whereupon,
3 , M.D.
4 a witness produced on call of the Defendants, having
5 first been duly sworn, was examined and testified as
6 follows:
7 (Exhibit 1 was marked
8 for identification.)
9 DIRECT EXAMINATION BY MR. FERRI:
10 Q. Good afternoon, Doctor. My name is Dennis
11 Ferri. I'm going to try to be as direct and brief as I
12 can with you.
13 A. Uh-huh.
14 Q. Have you had your deposition taken before?
15 A. Yes.
16 Q. Have you had it taken a number of times?
17 A. Sure.
18 Q. Okay. So you're familiar with --
19 A. Yes.
20 Q. -- the deposition process.
21 Let me hand you what I believe --
22 A. Uh-huh.
23 Q. -- I believe is your CV. Would you take a look
24 at it? I had it marked.

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1 A. Sure.
2 Q. Let me know it's accurate or if there's anything
3 of any --
4 A. This is my standard CV, yeah. Yeah.
5 Q. Okay. But nothing to be added or deleted?
6 A. No, not at this point. We're okay.
7 Q. Are you a board-certified orthopaedic surgeon?
8 A. Yes.
9 Q. For how long?
10 A.
11
12 Q. Have you had to be recertified?
13 A. Yes.
14 Q. Were you?
15 A. Yes.
16 Q. When?
17 A. I believe it was two years ago. That is not on
18 here. We need to add that. I was recertified two years
19 ago.
20 Q. Do you have any subspecialty or particular
21 interests in orthpaedic surgery?
22 A. Yeah. I'm speciality trained in the
23 reconstruction of the adult hip and knee replacement,
24 total joint replacements.

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1 Q. Hip and knee?
2 A.
3 I'm
4
5
6
7 Q. All right. Your practice here, you're part of a
8 private group?
9 A. Yes.
10 Q. ?
11 A. yes.
12 Q. How many physicians do you have?
13 A. Eight partners, one non-operative orthopaedic
14 surgeon.
15 Q. Do you do -- are you primarily the one who does
16 the hip and knee replacements or are there others that do
17 them also?
18 A. There are others. There are others.
19 Q. Who besides yourself does hip and knee?
20 A. Other than myself, Dr. Dr.
21 Dr.
22 Q. Okay. Who does the majority of them? Who does
23 most of them, let me put it that way?
24 A. Most likely myself and Dr.

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1 Q. All right. And how long have you been doing hip
2 and knee replacement? Since your fellowship?
3 A. Since 1993 when I arrived here.
4 Q. All right. Have you ever been sued as a result
5 of a knee or hip joint reconstruction?
6 A. No.
7 Q. Have you ever been sued at all?
8 A. No.
9 Q. Have you ever served as an expert witness in a
10 medical negligence case either of your or against a
11 physician?
12 A. No.
13 Q. Is this the first time then?
14 A. Yes.
15 Q. How are you -- how were you involved in this
16 case? I know you were Mrs. doctor.
17 A. The patient asked me. The patient asked me --
18 Q. All right.
19 A. -- and there was no question that I would be
20 helpful.
21 Q. All right.
22 A. Or willing to help. Excuse me.
23 Q. Have you, have you ever reviewed cases for the
24 purpose of possibly testifying as an expert in a medical

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1 negligence case?
2 A. No.
3 Q. Here's your file. I took a look at it already.
4 A. Yes.
5 Q. All right. Let's start with the last time you
6 saw Mrs. Can you tell me when that was, the
7 last time you saw her? I saw in there where she had seen
8 other of your partners.
9 A. Yes, yes.
10 Q. But I'm specifically asking about your exam of
11 her or your visit with her.
12 A. 4/27/2005.
13 Q. You have not seen her since then?
14 A. Not for her knee, no. Not professionally as my
15 patient, if that's your -- yes.
16 Q. All right. Was she supposed to return to you
17 after 4/27/2005?
18 A. There's nothing on here, there's nothing on here
19 saying about a repeat appointment. We can check my
20 records but, no, I don't believe so.
21 Q. So how would you have left it with her after
22 that visit?
23 A. At that point -- well, the thing is I keep
24 seeing her because I'm taking care of her husband. In

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1 terms of -- I see her routinely. I just performed knee
2 replacement on her husband. So I see her, you know, I've
3 been seeing her still since then and I ask her how
4 everything is going. But I have not seen her -- I have
5 not had a formal appointment with her, but that's kind
6 of, we're kind of birddogging her that way.
7 And I see her occasionally. The last time we
8 had a deposition for some reason my office called her and
9 had her, had her arrive. So she wasn't in on the
10 deposition or anything, but she had shown up so I said
11 hello to her and asked her how she was doing.
12 Q. All right. What is your understanding based on
13 those, I'll say not formal appointments, what is your
14 understanding of how her knee is?
15 A. Well, her knee is still painful. Her knee still
16 hurts, it's still painful. It's not as bad as it was in
17 terms of the pain. She's much happier in terms of how
18 the knee feels, it's stability, and the function of it.
19 Q. Have you done any informal exam or have you
20 just --
21 A. No, just looked at it. You know, nothing.
22 Q. Okay. I mean, have you looked at it and tested
23 it for stability?
24 A. No, no. Nothing like that. I know it's stable.

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1 Q. Do you know whether or not she's taking any
2 medication for her knee pain?
3 A. The last record I have from 4/12/06 says that
4 she is on Zoloft. So I do not see any record at this
5 point, but I do not know that 100 percent certain.
6 Q. And whose note were you just looking at?
7 A. I'm just looking at our last medication record
8 from 4/12/06.
9 Q. Is that a visit to Dr. [redacted]?
10 A. Dr. [redacted]. And that's the last time that was
11 updated. We update our medication records every time a
12 patient comes in.
13 Q. She has not contacted you for any medication
14 refills?
15 A. Looking at my records, let me see, because when
16 they call in -- well, I'm sorry. I'm sorry. I saw her
17 9/29/2005.
18 Q. 9/29?
19 A. 2005. After she had her peripheral nerve
20 surgery.
21 Q. Did you, did you examine her at that time?
22 A. At that point it was just a surgical follow-up
23 for the surgeon who did the surgery, removed her sutures.
24 Did not have to give her any pain medication at that

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1 point. I'm looking to see. I don't see any records in
2 here of any requests from her for any pain medication.
3 She recently was scheduled for surgery or had surgery and
4 the only medication reported is Zoloft.
5 Q. What surgery did she have recently?
6 A. Carpal tunnel release.
7 Q. On which, which side?
8 A. It appears to be the left.
9 Q. Going back to that 9/29/2005 visit where you saw
10 her, did you do an examination of her knee?
11 A. No, just took the sutures out, had the sutures
12 taken out and checked on her wound. It was a wound
13 check, surgical check.
14 Q. Do you have any documentation of what she said
15 about any complaints that she may have had about her
16 knee?
17 A. No.
18 Q. Nothing?
19 A. No.
20 Q. So as far you know she's functioning okay on the
21 knee?
22 A. Uh-huh.
23 Q. She's able to walk?
24 A. Yes.

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1 Q. Does she have a limp of any kind as far you
2 know?
3 A. From what I recall, not really, no.
4 Q. And you say you just performed surgery on her
5 husband?
6 A. Uh-huh.
7 Q. And that was a total knee replacement?
8 A. Uh-huh.
9 Q. Yes?
10 A. Yes.
11 Q. All right. And do you treat anyone else in the
12 family?
13 A. No.
14 Q. All right. Let's talk about your role as an
15 expert on the standard of care in this case and you've
16 been identified as a standard of care expert against
17 Dr. [redacted] and I'd like to know based on your review of
18 things what is the earliest breach of standard of care
19 that you attribute to Dr. [redacted]?
20 A. Well, we are addressing, or the patient is
21 addressing the revision surgery of the unicondylar knee
22 replacement to the total knee replacement.
23 Now, the events before that did not involve this
24 particular case is my understanding, so the unicondylar

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1 knee replacement, I certainly can speak about as well and
2 her result with that, but I'm specifically speaking about
3 the revision knee replacement on the left done by
4 Dr. [redacted]
5 Q. Okay. So then you have -- if I'm correct, you
6 would you have no opinions with regard to any breaches of
7 standard of care with regard to any treatment by
8 Dr. [redacted] up until the time of the total knee
9 replacement that he did; am I correct?
10 A. Can you repeat that?
11 Q. Sure. I just want to, I just want to identify
12 and make sure I identify all the opinions that you're
13 going to testify to eventually at trial, if this case
14 goes to trial, and I want to know in you're going to
15 testify that Dr. [redacted] breached any standard of care
16 prior to the -- before the surgery that he actually did
17 for the total knee replacement?
18 A. The only one I'll be speaking about is the
19 revision.
20 Q. All right. And I see that you've put some
21 X-rays on the --
22 A. Yes.
23 Q. -- board there?
24 A. Yes. Well, actually, I haven't. Mr. Gaston put

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1 those up there, but those are -- actually the middle one,
2 which I haven't looked at yet, that's a new one. I want
3 to make sure that's what we need, where it is, who it is.
4 This appears to be [redacted] [redacted]
5 That's [redacted] and that's [redacted]
6 Q. Okay. Now, do you have before you the operative
7 report, Dr. [redacted] operative report of his surgery,
8 which would have been December 10, 2003?
9 A. Yes.
10 Q. I have, or I will have, a copy of it in front of
11 me as well. And I'd like you to go through that and tell
12 me what, what in the operative report, if anything -- I
13 mean, it may not be in the operative report. But what in
14 the operative report constitutes a breach of standard of
15 care and if we do them in --
16 A. Well, it was just --
17 Q. -- chronological order that would be, that would
18 be great.
19 A. -- to start, his pre-op diagnosis is a failed
20 left unicondylar arthoplasty. From what we see there,
21 actually the unicondylar arthroplasty, which again, we're
22 not testifying to, looks to be done well. And it, I
23 don't believe the unicondylar has failed. I believe she
24 may have had arthritis elsewhere, which I believe was his

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1 contention as well.
2 Q. Okay.
3 A. Revising unicondylars can be difficult and there
4 are some problems with them and there are some pitfalls
5 that can happen to a surgeon revising a unicondylar.
6 Anesthesia was spinal, which is standard. Estimated
7 blood loss, negligible. Tourniquet time, one hour,
8 forty-five minutes, which is reasonable. Drained,
9 complications. Components used was a Zimmer.
10 I'm somewhat interested Dr. [redacted] used the
11 J&J unicondylar replacement. My understanding is he's
12 trained on J&J and has been using J&J for I guess about
13 almost twenty years and I see he put in a Zimmer knee, so
14 I wonder how familiar he is with this particular implant
15 and the reasons for switching. J&J has an excellent
16 track record. And that's just my own -- that's just
17 interesting. Something, something that interests me.
18 Q. Okay.
19 A. We have his operative report. Standard exposure
20 to the knee. Tibial component, tibial components. Well,
21 there's only one tibial component, but I guess he meant
22 to say the components were carefully examined, were not
23 loose. Significant wear under the patella, possibly
24 accounting for this patient's persistent pain. The

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1 unicondylar replacement was done I believe six months
2 earlier.
3 MR. GASTON: It was done, the unicondylar was
4 done 4/21/03.
5 THE WITNESS: Yes. So six months earlier --
6 well, eight months earlier she had the unicondylar
7 replaced and at that point I believe there was no wear
8 under her knee cap, according to his operative report.
9 Then in the interim there was an arthroscopic surgery
10 which revealed somewhere now there was significant wear
11 under the patella, which happened very rapidly in
12 eight months.
13 BY MR. FERRI:
14 Q. Well, he did the left knee unicondylar in April
15 of '03?
16 A. Yes.
17 Q. And then he did a left arthroscopic lateral
18 release in September of '03?
19 A. Yes.
20 Q. So that's --
21 A. That's five months.
22 Q. -- five months.
23 A. And then three months later was revising her
24 into a full knee replacement.

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1 Q. That's right. So was there any -- did I miss
2 something, is there something that you're saying is
3 unusual?
4 A. Just, just interesting that the knee degraded so
5 quickly.
6 Q. All right. I mean, is that something that can
7 happened with people or is that something that you
8 attribute to --
9 A. No, I mean, I guess it obviously can happen. It
10 happened here.
11 Q. All right.
12 A. Distal femoral cut was then made. And it
13 doesn't mention how he adjusted for that because the
14 distal femoral cut is usually taken off the medial femur
15 and when you remove a medial unicondylar replacement
16 there is bone loss there and if you reference off that
17 point you will raise the joint line, which he did, and
18 thus you're kind of chasing your tail after that because
19 you have to balance the knee. It makes it difficult to
20 balance the knee when your flexion extension gaps aren't
21 correct. But it's not a real -- what is the word I'm
22 looking for? Excuse me. It's not a very detailed
23 operative report. So it doesn't say if he adjusted or
24 not. And so it says he went through, put the full knee

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1 replacement in.
2 At this point, the components were cemented and
3 it says at that point we detected a snapping of the
4 popliteus tendon along the lateral border of the tibia
5 insert. We therefore opened the knee back up and tried
6 to replace the popliteus tendon. I think at this point
7 things, things are, are -- there's something going wrong
8 with the knee or there's something that he's not
9 comfortable with.
10 We then reclosed the knee and the popping
11 persisted. You know, tried to release the popliteus
12 tendon. The popliteus, popliteus tendon is a readily
13 evident anatomic structure in the knee. It's very easy
14 to find, it's very easy to release.
15 After that the knee was tested for varus/valgus
16 instability. Excuse me. We then reclosed the knee and a
17 popping persisted. We made another one-inch incision
18 over the posterior lateral aspect of the knee and
19 popliteus.
20 Q. Slow down. When you read, when you read --
21 A. I read very fast. I'm from New York.
22 Q. -- you make her life kind of hard.
23 A. We made another one-inch incision over the
24 posterior lateral aspect of the knee and the popliteus

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1 tendon is released through that and the remainder of the
2 popliteus tendon was removed from that incision. That's
3 very unusual. I'm not too familiar with that particular
4 technique for popliteus tendon release.
5 "After that, the knee was tested for varus to
6 valgus stability. The patient had some laxity because of
7 the posterior lateral release." He opens the knee up.
8 Now, this is the third -- well, really it's the fourth
9 time. He's opened it up the first time, closed it.
10 Reopened it, tried to release the popliteus tendon. Then
11 he did this lateral incision, released the popliteus
12 tendon and whatever else, because now there's some laxity
13 and the knee is a little bit looser.
14 He then opened -- when he's speaking "we," I
15 imagine most likely he's speaking of himself.
16 "Therefore, we opened the knee back up." So this is the
17 fourth time now he's been doing this knee -- he's doing
18 one knee replacement. This is the fourth time he's had
19 to either go back in or make another incision. "With
20 that the knee was stable to varus and valgus stress and
21 the popping of the popliteus tendon had been eliminated."
22 Q. What in there constitutes in your opinion a
23 breach of the standard of care for this type of surgery?
24 A. Well, I think, number one, you have to also base

Page 21

1 it on what I found when I first examined the patient in
2 my office, but --
3 Q. Okay. We'll get to that.
4 A. Yes.
5 Q. I'm going to let --
6 A. But what --
7 Q. -- you give all your opinions, but I just --
8 A. I find it, I find it --
9 Q. -- want to know, Doctor, anything in the
10 report --
11 A. Yes, the trying to release the popliteus tendon.
12 Dr. [redacted] is a very well-known, well-trained, highly
13 experienced joint replacement surgeon --
14 Q. Okay.
15 A. -- and I'm certain if he wanted to release the
16 popliteus tendon he could. Unless, of course, he was
17 having some difficulty with problems of unknown -- maybe
18 this is a new system that he's unfamiliar with. Maybe
19 the femur -- which I contend the femur was a little bit
20 oversized, so maybe it was blocking his view of it. But
21 it's unusual for a surgeon not to be able to see the
22 popliteus. I do knee replacements and you can get
23 exposure of it.
24 Saying that, that did not work so he attempted

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1 to come in her from the posterior lateral aspect, making
2 a separate incision on the outside of the knee. That is
3 unusual. I have never seen a report or an article
4 detailing that technique for release of the popliteus.
5 It's highly unusual. My contention as well is that at
6 that point he cut the lateral collateral ligament
7 complex, thus rendering the knee unstable.
8 At that point all of his components were
9 cemented in. Short of pulling them all out and putting
10 in a constrained prosthesis, of which I did at a later
11 date, this knee was not going to be stable. At that
12 point he went back in, because there was some laxity as
13 noted in his op note. I don't think he would have opened
14 it back up again -- this is now a fourth time -- unless
15 there was a problem with the knee.
16 He went from a 15 to a 17 millimeter space.
17 That's a 2 millimeter change. Relatively insignificant
18 change. Pretty much all that did was make the knee a
19 little bit tight in one aspect, but still loose in
20 another. It was a stop gap measure and in my opinion it
21 was ineffective. At that point, the tourniquet had been
22 up an hour and forty-five minutes, which is a long time
23 for a knee replacement. But with four separate openings
24 I can understand why it took so long. And I believe the

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1 knee was less than satisfactory.
2 Q. Okay. What is your understanding of the breach
3 of standard of care?
4 A. My understanding of the breach of standard of
5 care is something that's highly unusual or highly
6 irrelevant for an orthopaedic surgeon. I'm talking about
7 an orthpaedic surgeon's standard of care.
8 Q. Exactly.
9 A. A surgeon of Dr. reputation and
10 experience I would think should be able to fix the
11 problem the second time that he went back in, if there
12 was a problem. It appears to me he never really got a
13 good grip on this knee and I think going, going
14 repeatedly back and forth into this knee was a breach of
15 the standard of care.
16 Q. Okay.
17 A. And also possibly cutting a very important
18 ligament in the knee for stability, which I believe
19 happened during that surgery.
20 Q. Now, what was that ligament?
21 A. The lateral collateral ligament.
22 Q. All right. Now, you say it's possible that he
23 cut it. Did you --
24 A. I say it's highly likely he cut it through that

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1 posterior lateral incision he made.
2 Q. Did you, did you ever observe it being cut?
3 A. No, but I saw it cut when I went back in for my
4 revision surgery. It was incompetent and not there.
5 Q. So the lateral --
6 A. Collateral ligament.
7 Q. -- collateral ligament was not there?
8 A. It was incompetent. It had been rendered
9 incompetent. And that was, that was apparent to me at my
10 first exam of this woman.
11 Q. What did you see about it --
12 A. It was just --
13 Q. -- that made it incompetent?
14 A. There was nothing there. There was just some
15 soft tissue there.
16 Q. So you didn't see the ligament at all?
17 A. The ligament there's by testing. You feel it
18 when you get into the surgery and there's an actual
19 physical -- I mean, you could put your finger on it and
20 feel that it was not there.
21 Q. So the cutting of that ligament was something
22 that cannot be a, you say, recognized complication of
23 this type of surgery?
24 A. It can happen. It happens very rarely.

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1 Q. Okay.
2 A. If it does happen, in the hands of a highly
3 trained, experienced surgeon of Dr. reputation
4 it is recognized and it can be treated at that time.
5 Now, it happens to medial collateral ligaments as well.
6 This happens. He does lots of replacements, as I'm
7 certain he's told you.
8 Going in posterior laterally to make this
9 separate incision from the outside I saw, and I see, no
10 benefit to that other than the potential for cutting the
11 lateral collateral, which I believed happened. If he
12 indeed do that at that point, and I think it may have
13 been recognized because he says in his operative report
14 he noted some laxity, at that point it can be addressed.
15 And the way it's addressed is most likely, and the way
16 most experienced total joint surgeons would, is revise
17 the prosthesis to a constrained prosthesis that offers
18 internal stability so that we could give this a chance to
19 heal. This was not done at that point, so I believe
20 there was a failure to recognize the complication.
21 Q. Okay. What is a constrained prosthesis?
22 A. A constrained prosthesis is a prosthesis that
23 has what we call a varus/valgus constraint. It
24 substitutes for the medial or lateral collateral

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1 ligament.
2 Q. Okay. And you say you did that when you did the
3 revision?
4 A. It had to be done. The knee was unstable.
5 Q. Okay. And what is it that you did?
6 A. I revised her whole knee.
7 Q. But I mean, how, how do you make it a
8 constraint?
9 A. A constraint is a specific type of implant.
10 It's a different implant than a standard total knee
11 replacement. It needs to be, number one, available in
12 your hospital and I assume, although I don't know, that a
13 surgeon of Dr. experience would have this
14 available. I have these available in my operating room
15 at all times, as do all of my partners, in case this
16 problem does occur. Not that it's a common problem.
17 Q. Okay.
18 A. But this is usually, we usually use them for
19 revisions and especially in a revision situation you
20 would have these available.
21 Q. Okay.
22 A. And I'm not aware if he had them or not and that
23 may have been why we could not -- or he. Not we. That
24 may be why he did not do that at that time. Although, I

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1 would assume, again, that with his practice and in the
2 scope of his practice they were available. It would
3 involve, it would have involved taking her knee out,
4 pulling out the components, at least one if not two,
5 depending on the system he's using.
6 Q. Okay. So you're saying that when he ran into
7 difficulty that is something that sometimes happens,
8 although rare?
9 A. Yes.
10 Q. But at that point it's your opinion that he
11 should have recognized that situation and taken out what
12 he put in and put in a different implant?
13 A. I believe there was a failure to recognize a
14 problem. I think the fact that he had to go back in on
15 this knee three more times, a total of four times during
16 one surgical procedure, tells me that he was having a
17 problem, and/or in trouble, and/or didn't recognize it,
18 and/or did not have anybody to help him or could not turn
19 to anyone to help him.
20 Because at that point after three or -- after,
21 after two or three times, you know, perhaps it's time to
22 I say, "Hey, can you take look at this? What do you
23 think?" you know, to one of your partners or call in a
24 secondhand. I don't know if that was available either.

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1 Q. Okay. You don't know whether or not he had an
2 assistant?
3 A. He had a physician's assistant assist him. A
4 PA, physician's assistant, was his surgical assistant
5 from the operative report.
6 Q. But just so I understand you, you're saying that
7 when he ran into this difficulty he should have
8 recognized a complication and he should have put in a
9 constrained implant?
10 A. That would be one fix for it, yes. Other
11 options are to reconstruct the lateral collateral
12 ligament, with is very difficult. There are other
13 options, but with the snapping popliteus thing I'm not --
14 I haven't seen that as a very common or huge problem in
15 knee replacement or I don't recall any significant amount
16 of publications addressing it.
17 Q. Okay. Well, when he recognized this
18 complication, I want to make sure that I understand you,
19 too, that he should have taken out the components that he
20 already put in in order to put in the constraint?
21 A. Again, this is from retrospect. Yes. You would
22 have to take those out. Although, I am not familiar
23 with, 100 percent familiar with the Zimmer system. My
24 familiarity with it is that, yes, it would need to be

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1 taken out and have a different type of prosthesis. It
2 could be from the same manufacturer or different of a
3 constrained type put in that would have offered some
4 stability.
5 Number two, the other point which has not been
6 brought up yet which I also contend, is I believe his
7 tibial component, which is the component on the tibia, on
8 the shin bone was oversized significantly. Too big. If
9 a component is too big on the tibia, and his component is
10 overhanging laterally approximately I'd say at least 8 to
11 10 millimeters, and I don't have a lateral X-ray up
12 there, but if the component was that largely oversized
13 and hanging over laterally, that is where the popliteus
14 tendon is and that can be directly responsible for
15 causing that popliteus tendon to snap, if the component
16 was oversized hanging over laterally. Once again,
17 failure to recognize a technical problem or a technical
18 issue during his surgery. That may have been helped by
19 getting an X-ray, which is not noted either in his
20 operative report.
21 Q. Well, if you're in there doing the surgery can
22 you see if the tibial component is overhanging laterally?
23 A. Usually, yes. If you have adequate exposure.
24 But if have adequate exposure you can also address and

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1 see the popliteus tendon during knee replacement surgery
2 even after the components are in. He seemed to have
3 difficulty with that as well during this procedure.
4 Q. Is that always the case or can there be an
5 anatomical variance as far as the popliteus tendon?
6 A. Very rarely. Very rarely.
7 Q. Have you seen any in your practice?
8 A. The popliteus usually is where it should be when
9 I've seen it.
10 Q. Okay. You've not seen any anatomical
11 variance --
12 A. Not in my --
13 Q. -- as far as the popliteus --
14 A. -- not my experience.
15 Q. Okay. You've got to let me finish before you
16 answer so she can take us both down.
17 I guess my question to you is how many total
18 knee replacements do you do in a given month, year,
19 however you want to --
20 A. I do over two hundred hip and knee replacements,
21 at least two hundred hip and knee replacements in a year.
22 Q. And how long has that been the case?
23 A. I've been doing it here for thirteen years. I
24 wasn't doing that many initially, but have gotten up to

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1 that.
2 Q. Do you do more knees or more hips?
3 A. I do more knees than hips. Approximately 65,
4 70 percent knees.
5 Q. Let's go to the first time that Mrs. [redacted]
6 came in to see you.
7 A. Mrs. [redacted]
8 Q. Yes. And I think that was probably in '04.
9 A. 9/3/04.
10 Q. 9/3.
11 A. September 3rd, '04.
12 Q. All right. Now, she had been a patient of
13 Dr. [redacted]?
14 A. Yes.
15 Q. And are you aware that Dr. [redacted] had done
16 a --
17 A. I believe she had arthroscopy by him.
18 Q. Yes.
19 A. She had an arthroscopy by Dr. [redacted] in May of
20 2002. Arthroscopy, partial medial --
21 Q. Slow down. Slow down.
22 A. I'm sorry. Arthroscopy, partial medical
23 menisectomy, limited chondroplasty, femoral condylar on
24 5/23/02. So let me see. We may have that operative

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1 report.
2 Q. That's okay. I don't need to go to the
3 operative report. My question is, though, did you --
4 have you spoken with Dr. [redacted] about Dr. [redacted]
5 surgery?
6 A. No.
7 Q. Have you spoken with Dr. [redacted] about it?
8 A. [redacted] I'm not sure. I think I may have
9 spoken to him. I think I may have showed him her X-rays.
10 Q. Okay.
11 A. Although, I know what -- I wanted to get these
12 pictures of her unicondylar replacement. These are the
13 first time I saw these. Dr. [redacted] is one of our
14 specialists in partial knee replacement and I wanted to
15 have him look at the pictures of the partial knee
16 replacement to see if there was some interesting problem
17 or something that was unusual, but unfortunately I was
18 not able to see them until today. I gather there was
19 some difficulty finding them.
20 Q. Okay. What are those particular X-rays up
21 there? What do they show and, you know, when were they
22 taken?
23 A. Those are X-rays. The one on the right -- now,
24 these are all Dr. [redacted] X-rays from my knowledge.

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1 Q. Okay. The one all the way on the left that
2 you're looking at now, is there a date on that one?
3 A. 5/2/03? 5/12/03?
4 Q. So this is prior to her total knee by
5 Dr. [redacted]?
6 A. Yes.
7 Q. What does that show us?
8 A. The bones are well aligned. There may be some
9 slight, very slight medial joint space narrowing, but no
10 significant arthritis that I see. But arthroscopy --
11 give me one second. Arthroscopy is sometimes a little
12 more accurate in determining what the cartilage on the
13 end of the bone looks like. So it is not always a severe
14 change on the X-ray that requires an unicondylar
15 replacement, but that's not, not a horrible looking knee.
16 It's certainly not bone rubbing on bone in the medial
17 femoral compartment. She already had that arthroscopy by
18 Dr. [redacted] which showed some chondromalacia in the
19 medical compartment.
20 Q. Is that arthritis?
21 A. Chondromalacia, no. It's wearing of the
22 cartilage on the end of the bone.
23 Q. Okay.
24 A. To my records she did not have arthroscopy by

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1 Dr. and I'm unaware of whether or whether not he
2 had access to the operative pictures of Dr. .
3 Q. Okay. According to my notes Dr. did
4 the left knee unicondylar arthroplasty, femoral condyle
5 and tibial plateau?
6 A. Uh-huh.
7 Q. And then in September of '03 did a left
8 arthroscopic lateral release and then in December did the
9 revision of the left knee --
10 A. Yes.
11 Q. -- unicondylar?
12 A. Okay. That's what I have here. I'm not aware
13 if there's anything in that. Yes.
14 Q. You were talking about -- I'm sorry. Let's stay
15 with the X-rays. The middle X-ray, what does that show
16 us?
17 A. The middle X-ray is an X-ray of the unicondylar
18 prosthesis. It's one view.
19 Q. Which view is it?
20 A. AP view. Posterior done September of '03 of a
21 unicondylar knee replacement.
22 Q. Okay. What does it look like to you?
23 A. It's hard to tell without the lateral as well,
24 but it looks like it was done relatively reasonably. It

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1 looks like there may have been a little, a little
2 aggressive tibial cut done, which happens sometimes. It
3 means you take off a little, a little, a little more
4 bone, but that happens and it was made up with extra
5 plastic. You take off a little extra bone and you put in
6 a little extra plastic.
7 Q. Okay. And what's the --
8 A. It appears to be aligned very well, but again I
9 had not seen these until today and I have not reviewed
10 them with my partner, who is a unicondylar specialist.
11 Q. Okay. When you talk about alignment, what are
12 you referring to?
13 A. Alignment is the straightness of the leg.
14 Q. So are you saying that the alignment in the
15 first picture that we talked about is pretty good?
16 A. Yeah. It's a little bit of, a little bit of
17 deformity, but not a severe deformity by any means. It's
18 not bone rubbing on bone. Not severe at all.
19 Q. And of course, you feel the same way about the
20 second one?
21 A. Well, the second one she's already had surgery.
22 The alignment appears acceptable.
23 Q. And in the third one, where are we there?
24 A. The third one is after revision surgery by

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1 Dr. of the unicondylar replacement.
2 12/30/03. This is -- now, this was the Johnson
3 & Johnson prosthesis and now this is a Zimmer prosthesis.
4 Different company.
5 Q. What does that show you?
6 A. It shows me that, in my opinion, the tibial
7 component is oversized.
8 Q. And the tibial component being the bottom
9 component?
10 A. The bottom component. The femoral component
11 most likely is oversized. The joint space was elevated.
12 The joint line. Excuse me. Not joint space. You can
13 strike that. The joint line has been elevated.
14 Q. Now, where is the joint line?
15 A. The joint line is where the normal joint is and
16 there are anatomic, there are regular anatomic
17 variations. But with the joint line there are usually
18 some different, different parameters, but one of them may
19 be about 2 centimeters from the medial epicondylar here,
20 epicondyl, and this is the joint in here. That's where
21 the joint is.
22 One of the fundamentals of knee replacement
23 surgery is maintaining your joint line within reason.
24 Sometimes it will be elevated slightly. The problem with

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1 unicondylar knee replacements, number one, even though
2 it's so -- patients are told it's a minimally evasive,
3 small procedure. It actually does take away a fair
4 amount of bone that makes the revision difficult for some
5 surgeons because there are numerous pitfalls that can,
6 that can happen to them. Number one is they now have to
7 deal with a significant amount of bone loss on the tibial
8 side, especially after pulling this out. There can be
9 even more bone loss there.
10 Number two, when they remove the femoral
11 component there's going to be femoral bone loss and
12 usually we reference off this medical condyle in here of
13 the femur. We usually cut 10 millimeters off the medial
14 condyle. But if we've already cut some off here, then
15 you remove this and you lose more bone with the cement.
16 If you're referencing gig (sic) if you don't make up for
17 that you end up cutting more femur, raising the joint
18 line, which is I suspect what happened here.
19 The joint line was raised about a centimeter.
20 Once you raise the joint line to that extent you can
21 throw off the mechanics of the knee if it is not
22 recognized. Sometimes surgeons with raising the joint
23 line will find that they have some element of instability
24 and flexion and sometimes they will then go to a bigger

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1 prothesis to make up for that, which will give them
2 stability in flexion, but may not give them stability in
3 extension or they may end up --
4 (Deponent asked to slow down by reporter.)
5 The problem is you're kind of chasing your tail.
6 Sorry. Technical stuff.
7 Q. Let's go to your note.
8 A. Yes.
9 Q. And this is the first time you are examining
10 her; am I correct?
11 A. Yes, yes.
12 Q. All right. So you say the left knee shows good
13 range of motion minus 5 to 115 degrees?
14 A. Uh-huh.
15 Q. Now, what range of motion are we talking about?
16 A. Range of motion of the knee minus 5 is
17 extension, 115 is flexion.
18 Q. All right. What's the full range?
19 A. The standard range of motion for a knee
20 replacement, a standard knee replacement, older designs,
21 zero to 125 degrees.
22 Q. That's post-knee replacement?
23 A. Correct.
24 Q. That's what your -- would that be optimal, what

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1 you just said, zero to 125?
2 A. Yes. That's, that's what -- that's optimal.
3 There are patients who achieve more flexion. There are
4 new designs which may allow more flexion.
5 Q. Okay. But we're talking about here and --
6 A. We're talking about this particular patient with
7 this particular knee replacement, yes.
8 Q. So in the year 2003 is this an adequate range of
9 motion?
10 A. Certainly. Range of motion wasn't her problem,
11 though.
12 Q. All right. Now, you say she has a medial,
13 medial parapatellar incision. She also has a lateral
14 incision. All right. Now, to get on with the exam, you
15 say the knee showed some instability to anterior and
16 posterior draw and also opens up with varus stress.
17 Would you explain that?
18 A. To open up the varus stress you take a knee, you
19 hold it out, you bend it a little bit and then you check
20 it back and forth to see if the ligaments are attached.
21 This knee opened up. When I went to bend it in to make
22 it bow-legged it showed that the, to me -- to my, to my
23 exam that the lateral collateral ligament was
24 incompetent.

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1 Q. Okay. And what is the anterior and posterior
2 draw, is that --
3 A. Actually this is -- and the knee showed some
4 instability to anterior draw. That's normal. Because in
5 a knee replacement we, we cut the anterior cruciate
6 ligament. And posterior draw, she just had a little
7 laxity because this is a cruciate-retaining prothesis and
8 it just shows that the knee was kind of, kind of just a
9 little bit lax in all planes and motion, except valgus
10 stress.
11 Q. All right. Now, you say here the tibia is
12 oversized --
13 A. Uh-huh.
14 Q. -- an overhanging laterally at least 8 to 9
15 millimeters?
16 A. Yes.
17 Q. Are there reasons to oversize a tibia on the
18 lateral side, acceptable reasons?
19 A. I don't know.
20 Q. Okay. Fair enough. Now, you say the femur
21 appears to be oversized as well. Do you hold a firm
22 opinion in this case that the femur was oversized?
23 A. I believe that I hold a very firm opinion that
24 the femur was oversized, as well as the tibia.

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1 Q. Now, you say joint line has been raised a
2 significant amount.
3 A. Yes.
4 Q. How much was the joint line raised? Were you
5 able to --
6 A. I believe it was raised about 10 millimeters.
7 Q. Is that within acceptable parameters or not?
8 A. I believe not.
9 Q. And what would be acceptable for this type of
10 surgery?
11 A. With a posterior cruciate-substituting
12 prothesis, of which this is not, usually within 2 to 5
13 millimeters they talk about raising the joint line. With
14 these types of prostheses, because you have an anatomic
15 structure, the posterior cruciate ligament back there
16 that is sensitive to where your joint line is. You need
17 to be a little more cognizant of your joint line and/or
18 you need to release and/or recess the posterior cruciate
19 ligament to tension it correctly so that the knee will
20 flex and extend and not be unstable and there was no
21 mention made of that in the operative report. So I
22 believe it was raised a significant amount that it had an
23 effect on her result.
24 Q. Now, let's make sure that I understand that

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1 you're talking about the system that Doctor --
2 A. And the system he used.
3 Q. -- [redacted] used?
4 A. In the system used on this X-ray it is important
5 that the joint line be maintained in its relatively
6 normal position, which it was not.
7 Q. And this is the Zimmer system?
8 A. This is a Zimmer system that he used from his
9 operative report and from X-Ray. Yes.
10 Q. What is acceptable joint elevation using the
11 Zimmer system?
12 A. Using any posterior cruciate-retaining system,
13 not only the Zimmer, using -- I'm talking more of the
14 system in terms of whether or not he kept the posterior
15 cruciate ligament in a retaining -- see, there are two
16 types of knee replacements. You can either cut the
17 cruciate ligament or keep it. That's a personal
18 preference only and the results are equal according to
19 the investigators.
20 But if you're going to keep the posterior
21 cruciate ligament, the joint line needs to be maintained
22 a little bit closer to normal. This was a posterior
23 cruciate-retaining design. He left the cruciate
24 ligament, which is fine, but then you need to pay a

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1 little more attention to your joint line, especially in a
2 revision situation.
3 Q. Okay. Is it your opinion that it was a breach
4 of the standard of care for Dr. [redacted] to leave the
5 joint line elevation that he did.
6 A. I believe that at the time of the revision it
7 may not have been recognized that the, that he had bone
8 loss off the femur and he raised the joint line. But in
9 the hands of a highly trained, highly experienced joint
10 surgeon that is unacceptable. That is something that we
11 are very much aware of when doing revision surgery.
12 Q. Do you consider yourself on the same level with
13 Dr. [redacted] higher or lower in terms of training
14 specialty capability?
15 A. I don't know him personally. I don't know of
16 his skills. I know of his reputation in the area and
17 he's been in practice longer than me, so I'm certain he
18 has more experience than me.
19 Q. Okay. You don't know him personally?
20 A. No, I do not.
21 Q. You've never had --
22 A. I met him at a meeting, but I don't know him.
23 Nothing more than saying hello and shaking his hand --
24 Q. All right.

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1 A. -- maybe ten years ago.
2 Q. Okay. Do you know if any of the other partners
3 here know Dr. [redacted]?
4 A. I do not. I imagine we've had dealings with his
5 former group, of which he is not a member at this time.
6 I believe when he had the unicondylar compartmental
7 replacement done, that was when he was with the [redacted]
8 group, and when he had the revision done he had moved out
9 of state to practice in Delaware.
10 Q. Okay. So did this particular group have some
11 involvement with Dr. [redacted] former group?
12 A. We have a collegial relationship with the [redacted]
13 group and sometimes we have meetings where we'll bring in
14 a speaker and both groups are there.
15 Q. But you've never, this group and the [redacted]
16 group have never been together at any time?
17 A. Oh, no. There's no, there no business --
18 Q. Relationship?
19 A. -- relationship or -- no, no. It's purely a
20 collegial, academic-type thing.
21 Q. You go on to say there's a large polyethylene
22 spacer. Is that significant in any way?
23 A. Well, it shows that the large polyethylene
24 spacer -- the reason I mention that is, once again, if

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1 you raise the joint line you have to fill it with
2 something. You can raise the joint line and put your
3 standard 9 or 10 or 11 millimeter polyethylene spacer in,
4 so you need to put a larger spacer in. It's just
5 indicative.
6 You know, everything kind of -- it's kind of a
7 snowball effect. One problem begats another, begats
8 another. That's the problem with replacement surgery,
9 failure to recognize the first problem and you start
10 getting more problems and then you have to go back in the
11 knee a second time or try and do a release from outside
12 the knee or then open it up again and put a different
13 plastic in. That's how problems happen in these
14 surgeries. You know, it's kind of like chasing your
15 tail, as they call it. So failure to recognize these
16 problems sometimes causes further problems.
17 Q. Okay. Now, when you did your revision did you
18 take out the components that he put in?
19 A. Yes.
20 Q. And you put in entirely new components?
21 A. Yes.
22 Q. And when you say that the tibia is oversized, to
23 what extent was it oversized?
24 A. It was overhanging a significant amount past the

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1 bone.
2 Q. Okay. I assume that these tibial --
3 A. And if you give me one second I will find my
4 operative report.
5 Q. Okay.
6 A. Because without that... there we go. And from
7 my operative report -- and I can go over that with you.
8 Q. Okay. I have it in front of me.
9 A. Her history is she had the unicondylar knee
10 replacement in April of '03. She continued to have pain.
11 Dr. performed the arthroscopy September '03.
12 Then he did the knee replacement three months later and
13 then one month later he manipulated her for stiffness.
14 The patient came to me when he had told her that
15 he was going to perform another arthroscopy. At that
16 point she was a little bit unsure about that and came to
17 me for my opinion. And then on my operative report dated
18 10/26/04 I found on my indications -- but in my
19 indications "It should also be noted that the patient at
20 the time of her placement of total knee," by
21 Dr. "had a lateral incision made to release a
22 snapping structure." These are my words from my
23 operative report. "I'm not exactly sure what this was,
24 but during surgery" I found "we found that the" --

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1 Q. Slow down now.
2 A. "I'm not exactly sure what this was, but during
3 surgery we found that the lateral collateral ligament was
4 quite incompetent, so I think this may have been what was
5 released." And then on my operative procedure, standard
6 procedure, I'll hit on the important parts. There was no
7 significant bone loss noted in removing the femur to
8 balance her knee and achieve acceptable alignment. I had
9 to place distal augments on the femur to bring her joint
10 line back down to its acceptable position.
11 And the tibial component was a rather small
12 size 2 tibial component. But with the system I was
13 using -- and this may have been a problem, with
14 unfamiliarity of the system he was using -- with the
15 system I was using you can mix and match. You can use a
16 small tibia with a larger femur. That certainly would
17 have helped one problem that had occurred during his
18 surgery.
19 Also, just did some work to even up the gaps in
20 the knee. The patient still had laxity laterally,
21 though. You cannot -- no matter what I did during the
22 surgery she had no -- she had an incompetent lateral
23 collateral ligament. That was, I believe that was cut
24 during Dr. surgery, the second one. So at

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1 that point --
2 Q. Let me ask you something about that. You say
3 the patient unfortunately still has laxity laterally --
4 A. Yes.
5 Q. -- because of what you presume is lack of --
6 A. Yes.
7 Q. -- lack of lateral ligament from the lateral
8 incision?
9 A. Um.
10 Q. Why do you use the word presume?
11 A. Because I'm certainly not sure, but that was my,
12 that was my opinion at the time. This is an operative
13 note dictated afterwards.
14 Q. Okay. Well, you would have been able to see if
15 it was incompetent; right?
16 A. It was incompetent. I presume the incompetence
17 was caused by a surgeon. Not me.
18 Q. Is there anything that can be done for the
19 lateral collateral ligament? Is there anything that can
20 be done for that, you know, to strengthen it?
21 A. There's nothing that can be done to strengthen
22 it. There are techniques to reconstruct the ligaments
23 within the knee. Usually in the domain of the sports
24 medicine doctors they can do lateral medial

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1 reconstructions.
2 In knee replacement surgery I have reconstructed
3 medial ligaments and they can be reconstructed. The
4 lateral is a little more challenging. I've never had to
5 do that in a knee replacement, but what we do because of
6 the forces across the knee replacement it not as
7 critically important to reconstruct it, but you do need
8 to substitute for it and that's when at this point in her
9 surgery I decided to place a CCK constrained condylar
10 prosthesis.
11 Q. What system did you use for reconstruction?
12 A. I used the ExacTech Revision Knee System.
13 Q. And what size tibial component did you?
14 A. Size 2.
15 Q. And what size femoral?
16 A. Size 3.
17 Q. How do they compare with what Dr. used?
18 Can you make the comparison?
19 A. You could make the comparison, but without
20 seeing detailed spec sheets on either I couldn't -- but I
21 can tell you that a size 2 was almost, almost -- it
22 should be smaller than that or it will be smaller than
23 that when we look at her X-rays.
24 Q. And would the femoral be smaller as well?

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1 A. I presume it would as well.
2 Q. But you've never looked at it --
3 A. Never compared the two.
4 Q. -- spec sheet wise?
5 A. Correct. And you have to -- at this point it
6 really wouldn't matter. At this point what -- at this
7 point I'm trying to salvage something. This lady has had
8 multiple operations. She has a difficult problem. This
9 is one -- went in once, went in one,
10 two, three and was ready to go a number four time. And
11 by the third procedure she'd essentially had four
12 separate procedures.
13 So this lady has had numerous operations in this
14 knee. This is a knee that is, you've kind of got to work
15 with it and see what works in it. You have to go in
16 knowing what the problem is. The problem is it was
17 unstable. The pain that she was having from the knee was
18 a totally different problem which would then need to be
19 addressed, because with a knee that's been multiply
20 operated on pain is going to be an issue no matter how
21 good the surgical result is on X-ray or clinically. We
22 still have a pain issue because she has had multiple
23 operations on this knee in a short period of time and
24 multiple incisions and that would need to be addressed as

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1 well.
2 Q. Okay. Is her problem -- are her knee problems
3 now, as they exist today as you understand them, related
4 to instability?
5 A. No.
6 Q. What are they related to?
7 A. Her knee problems now are just related to a lady
8 who is sixty years old and -- well, not sixty. Excuse
9 me. She was sixty. I'll do the math. Sixty -- she's
10 coming up on a sixty-two-year old lady, sixty-one-year
11 old lady who in the course of six months had numerous
12 surgical procedures. The last one not done well in my
13 opinion and required her to have one to make it right.
14 Q. All right.
15 A. She now has some pain, which is -- and actually
16 has seen -- I sent her up to see a peripheral nerve
17 surgeon problem. This is a problem we see in the
18 multiply-operated. Patients can get peripheral neuromas.
19 It has been documented in the literature that finding
20 these neuromas and removing them can be helpful in these
21 patients with these patients who definitely -- they're
22 not going to get a result like a first time knee
23 replacement, a well-planned, well-thought out, well-done
24 knee replacement.

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1 Q. When you do knee replacements, and you've told
2 me that you've done hundreds of them, are there a
3 percentage of people that no matter how well you do the
4 knee replacement it doesn't -- they still have pain
5 issues following it?
6 A. There's a small percentage of patients that will
7 have pain. The orthpaedic literature quotes 95 percent
8 good or excellent results with regard to pain.
9 Q. Now, a knee replacement done, given a person of
10 Mrs. age, would that make any difference as to
11 the percentage or the success rate, complete success rate
12 of a total knee replacement?
13 A. No.
14 Q. All right. So no matter what the age is, it's
15 95 percent?
16 A. Orthopaedic literature quotes 95 percent good or
17 excellent results.
18 Q. Now, what is considered a good or excellent
19 result? Elimination of all pain?
20 A. Not elimination of all pain, but most of the
21 pain. There are scoring systems that the university's
22 use. But you know, pretty much you base it on the
23 patient's satisfaction with their replacement. But her
24 problem was not pain. I mean, she had a painful knee,

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1 but her problem when she came to see me was not that her
2 knee was painful. People can have pain from knee
3 replacements. Her problem is that her knee when she saw
4 me was unstable --
5 Q. I understand.
6 A. And there were technical problems related to her
7 surgery that needed to be fixed first.
8 Q. All right.
9 A. And then, and then --
10 Q. Go on.
11 A. -- see what her result is.
12 Q. All right. So you fixed the instability
13 problem?
14 A. Yes.
15 Q. And she doesn't have any instability problems?
16 A. No. She can't -- well, she should not with the
17 prosthesis I put in.
18 Q. And if she does?
19 A. It would be highly unusual, but it can happen.
20 And it can happen if the constrained plastic portion of
21 the tibial breaks or wears, which is a risk in putting in
22 these prostheses, which is why we don't do them
23 routinely. Which is why we would prefer not to do them.
24 And unfortunately for Mrs. she's sixty-one years

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1 old and she now has a prosthesis that may wear quicker
2 and may need further surgery in the future. But at that
3 point, at the point that I performed her surgery that was
4 the only prosthesis that would take care of her problem.
5 And in my practice we try to avoid using constrained
6 prostheses if at all possible because of their propensity
7 for increased wear and because of their increased
8 constraint.
9 Q. How long does a typical knee replacement last
10 non-constrained?
11 A. The --
12 Q. That's a word?
13 A. Yes, it is. A knee replacement. The problem
14 with most knee replacements is most of the designs we're
15 using today do not have documented long-term results, bu
16 orthpaedic literature quotes between ten to
17 fourteen years, 94 to 95 percent of replacements -- of
18 designs similar to both knees that she had, the first one
19 by Dr. [redacted] nd then the design that I used in the
20 unconstrained mode, 94 to 95 percent at fourteen years.
21 Q. And with constrained?
22 A. The results are not as good because of the --
23 some investigators may report ones that may be equal, but
24 usually are thought not to be good because of the

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1 increased force that's put across the tibia which may
2 result in increased plastic wear and may necessitate
3 further revision surgery.
4 Q. Okay. When you gave me these statistics of,
5 say, 95 percent are considered good to excellent, were
6 you referring to unrestrained or restrained or a
7 combination?
8 A. In the literature, in the literature that would
9 be a standard primary knee replacement.
10 Q. So that does not include constrained?
11 A. Correct.
12 Q. Is there any, is there any statistic for
13 constrained?
14 A. I'm certain there is, but I'm not going to quote
15 you a number at this point.
16 Q. Out of every hundred knee replacements that you
17 do how many are constrained and how many non-constrained?
18 A. Out of every hundred, it would be very rare to
19 put in a constrained prosthesis.
20 Q. Would it be one or --
21 A. On a primary? Yeah. You don't put a
22 constrained on the primary because you want to balance
23 the knee. Now, if I was doing a primary knee replacement
24 and one of the ligaments was cut and I couldn't

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1 reconstruct, I'd put a constrained in. The difference in
2 putting in a constrained technically in a well-trained
3 revision surgery, the surgery is not a problem.
4 Technically it can be done. It's not a big deal because
5 it's done so infrequently. But your goal is to not use
6 them if at all possible. Your goal is to know when to
7 use them and when it's appropriate to use them.
8 Q. Okay. You did this, you did your revision about
9 ten, eleven months, I guess, following Dr. [redacted]
10 A. Yes.
11 Q. Is that a standard time to do it?
12 A. There's no stand time for a poor knee
13 replacement.
14 Q. Okay.
15 A. I could have waited till next year. That knee
16 still would have been bad. It that wasn't getting
17 better. Ligament -- a lateral collateral ligament
18 doesn't heal and the joint line wasn't going to move back
19 down and the tibial component wasn't going to get
20 smaller.
21 Q. Did she, did Mrs. [redacted] have osteoporosis?
22 A. I don't know. I don't have a bone density test
23 in front of me.
24 Q. Does a person with osteoporosis, do they respond

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1 as well to knee replacements? Does it make any, does
2 it -- or stated otherwise, does it effect any knee
3 replacement?
4 A. It should not with a cemented replacement. I
5 don't know if it has any relevance to this particular
6 case.
7 Q. I'm just asking hypothetically; if it does, do
8 you do the knee replacements any different?
9 A. If you are -- I cement all my knee replacements,
10 so cement seems to work better.
11 Q. If somebody is osteoporotic, do you need to make
12 sure that you -- sorry. Strike that.
13 If somebody is osteoporotic would you err on the
14 side of having a little lateral overhang?
15 A. Osteoporosis is a diagnosis that can be made by
16 a bone density test.
17 Q. Okay.
18 A. So if she had a bone density test showing she
19 was osteoporotic you certainly may feel that way, but I
20 don't know of any report in the literature that
21 recommends that.
22 Q. Okay. Did you refer her to Dr. [redacted]
23 A. Yes. I actually referred her to Dr. [redacted] in
24 Baltimore, but I believe at that point he was either not

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1 taking patients or didn't participate with their
2 particular insurance. And I was very familiar with Dr.
3 [redacted]s work with regards to the painful
4 multiply-operated knee replacements.
5 Q. Now, you saw her on the 9th. I'm sorry. You
6 saw her on September the 3rd for the first time and did
7 you ask her to go through any additional therapy or
8 anything?
9 A. Therapy would not have helped.
10 Q. All right. I see it's only not quite two months
11 before you did the surgery. So therapy would not helped?
12 A. Not in my opinion.
13 Q. Dr. [redacted] had suggested alices of adhesions,
14 I believe, which M[redacted] declined.
15 A. Adhesions are structures that are holding a knee
16 tight or causing it to be stiff. That was not her
17 problem.
18 Q. Okay.
19 A. And that would be another -- he already had done
20 an arthroscopy. After the unicondylar didn't do well, he
21 did an arthroscopy, which didn't appear to help the
22 unicondylar very well. So they did the knee replacement,
23 which didn't do very well. Then he manipulated it and it
24 still wasn't doing well, so he wanted to do another

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1 arthroscopy. That's when the patient got a little bit
2 concerned because there was a pattern developing, I guess
3 in her mind. And I don't see where arthroscopy would
4 have helped with an incompetent lateral collateral
5 ligament.
6 Q. May I see the last note where you examined her?
7 I think you said you found one in --
8 A. September.
9 Q. -- '04 or '06?
10 A. Yes. Just this, this little note right here at
11 the bottom of the page.
12 Q. Thanks.
13 THE WITNESS: Would you excuse me for one secon
14 so I can grab a drink of water?
15 MR. FERRI: Yes.
16 (Whereupon, the witness left the room and there
17 was a discussion off the record.)
18 BY MR. FERRI:
19 Q. The 9/29/2005 note that you have --
20 A. Yes.
21 Q. -- your plan for her was activities as
22 tolerated, follow-up as needed?
23 A. Yes.
24 Q. All right. And she has not contacted you to

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1 follow-up?
2 A. Again, not, you know, through the office for an
3 appointment or anything like that, but with my
4 frequent -- I've been treating her husband for his knee
5 and with my frequent exposure to her I just happen to ask
6 her there. But you know, at this point she pretty much
7 knows what she has is what she has. I mean, there's
8 nothing else that can be done at this point other than,
9 you know, to give her some time and see what we get.
10 Q. All right. Do you recall her ever saying to you
11 during those informal discussions when you're treating
12 her husband that, you know, anything to the effect like,
13 "Doctor, I've got to set up an appointment with you. You
14 know, I really need you to take a look at this" or
15 anything along those lines?
16 A. No. I mean, I made it clear to her that if she
17 needs to see me, I'm here. I also made it clear to her
18 there wasn't anything else that could be done so another
19 appointment wouldn't change anything. We have done all
20 we can do.
21 Q. You mentioned somewhere along the line about a
22 J&J system.
23 A. Yes, Johnson & Johnson.
24 Q. Oh, Johnson & Johnson?

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1 A. Johnson & Johnson.
2 Q. And that's the system used by Dr. [redacted]?
3 A. It was used on the --
4 Q. Unicondylar?
5 A. -- unicondylar. But however many months later,
6 six, eight months later he was then using the Zimmer
7 system. I don't know how long he had been using the
8 Zimmer system for, but when doctors are using these
9 systems sometimes being unfamiliar with it may sometimes
10 lead to these type of problems.
11 Q. Okay. My last question, could I get a copy of
12 the documents in your file after 4/27/2005, because
13 that's where I end?
14 A. I'm certain you could.
15 Q. Would you, could you make a copy --
16 MR. GASTON: I'll take care of it.
17 BY MR. FERRI:
18 Q. -- of those and send those to me?
19 A. Sure, sure. Can you take care of that?
20 Mr. Gaston can take care of that.
21 MR. GASTON: Okay. Be glad to do that.
22 BY MR. FERRI:
23 Q. And just let me double-check. I think I've
24 asked you everything I want. You said you had given

1 depositions before. In what kind of --
2 A. Motor vehicle accidents, Workmans' Comp type
3 deals. I don't --
4 MR. FERRI: Okay. Thank you.
5 THE WITNESS: You're welcome. My pleasure.
6 MR. GASTON: Doctor, you have the right to read
7 the testimony and I think that's probably a good idea.
8 THE WITNESS: Sure. Okay.
9 ([redacted] Exhibit 2 was marked
10 for identification.)
11 (Whereupon, the proceedings were concluded at
12 5:25 p.m. and the deponent elected to read the
13 transcript.)
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1 ERRATA SHEET
2 IN RE: [redacted] V. [redacted] AND [redacted]
3 RETURN BY:__________________________
4 PAGE LINE CORRECTION AND REASON
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1 CERTIFICATE OF SHORTHAND REPORTER - NOTARY PUBLIC
2 I, Daphne S. Hurley, Registered Professional
3 Reporter, the officer before whom the foregoing
4 deposition was taken, do hereby certify that the
5 foregoing transcript is a true and correct record of the
6 testimony given; that said testimony was taken by me
7 stenographically and thereafter reduced by computer to
8 typewriting under my supervision; and that I am neither
9 counsel for or related to, nor employed by any of the
10 parties to this case and have no interest, financial or
11 otherwise, in its outcome.
12 IN WITNESS WHEREOF, I have hereunto set my hand
13 and affixed my notarial seal this 18th day of July 2006.
14
15 My commission expires:
16 August 1, 2006.
17
18
19
20 __________________________
21 NOTARY PUBLIC IN AND FOR THE
22 STATE OF MARYLAND
23
24