STATE OF ILLINOIS)
) SS.
COUNTY OF MCHENRY)

IN THE CIRCUIT COURT OF THE TWENTY-SECOND JUDICIAL CIRCUIT, MCHENRY COUNTY, ILLINOIS

PAUL DULBERG, Plaintiff, vs. DAVID GAGNON, Individually, and as Agent of CAROLINE McGUIRE and BILL McGUIRE, and CAROLINE McGUIRE and BILL McGUIRE, Individually, Defendants.	)	Case No. 12 LA 178

The deposition of

DR. SCOTT SAGERMAN

October 15, 2013

Reported by:
Jill S. Tiffany, CSR

VAHL REPORTING SERVICE, LTD.
(847) 244-4117
11 N. Skokie Highway, Suite 301
Lake Bluff, Illinois 60044
and
53 West Jackson, Suite 656
Chicago, Illinois 60604

The deposition of DR. SCOTT

SAGERMAN, taken before Jill S. Tiffany, CSR, a notary public within and for the County of Lake and State of Illinois, on October 15, 2013, at the hour of 9:24 a.m., at 515 West Algonquin Road, Arlington Heights, Illinois.

APPEARANCES:

MR. ROBERT LUMBER, of the
Law Offices of Thomas J. Popovich, P.C.
3416 West Elm Street
McHenry, Illinois 60050,

appeared on behalf of plaintiff;

MR. PERRY A. ACCARDO, of the
Law Office of Steven A. Lihosit
200 North LaSalle Street, Suite 2650
Chicago, Illinois 60601,

appeared on behalf of Defendant David Gagnon;

MR. RONALD A. BARCH, of the firm of
Cicero, France, Barch & Alexander, P.C.
6323 E. Riverside Boulevard
Rockford, Illinois 61114,

appeared on behalf of Defendants Caroline McGuire and Bill McGuire.

I N D E X

WITNESS:

DR. SCOTT SAGERMAN

EXHIBITS:

(Exhibit No. 1 was marked for identification.)

DR. SCOTT SAGERMAN,

called as a witness and having been first duly sworn under oath, was examined and testified as follows:

E X A M I N A T I O N

BY MR. ACCARDO:

Q. Doctor, could you please state your name and spell it for the court reporter?

A. Scott David Sagerman, S-A-G-E-R-M-A-N, M.D.

MR. ACCARDO: Let the record reflect this is the discovery deposition of Dr. Scott Sagerman taken pursuant to notice, taken in accordance with the Rules of the Circuit Court of McHenry County, the Rules of the Supreme Court of the State of Illinois and any other applicable Local Court Rules.

Q. Good morning, Dr. Sagerman. I'm going to be asking you some questions today about a patient of yours by the name of Paul

Dulberg, okay?

A. Yes.

Q. You've given depositions before?

A. Yes.

Q. You're familiar with the ground rules governing depositions?

A. Yes.

Q. Now, we've been tendered a copy of your C.V. which we've marked as Exhibit No. 1 for identification. Is that relatively current and up-to-date?

A. Yes.

Q. And what kind of doctor are you?

A. Orthopedic surgeon.

Q. And do you have a specialty within the orthopedic field?

A. Yes.

Q. And what is that?

A. Hand and upper extremities.

Q. And you're currently affiliated with Hand to Shoulder Associates?

A. Yes.

Q. And that is in Arlington Heights, Illinois?

A. Yes.

Q. And that's where we're located today; is that correct?

A. Yes.

Q. Now, do you have any independent recollection of Paul Dulberg?

A. Somewhat.

Q. You have your chart here today for Mr. Dulberg; is that correct?

A. Yes.

Q. And what you have in front of you, does that comprise your entire chart for Paul Dulberg?

A. I think he had a Volume 1 chart from previous treatments in 2003 and 2004. I don't have that whole chart, but I have the typed office notes from that chart.

Q. Okay. And then in regards to this accident or care and treatment starting in 2012, you have your complete chart for Mr. Dulberg; is that correct?

A. Yes.

Q. Feel free to refer to your records and your notes when you need to. Now, the

accident that we're here to talk about took place on June 28th of 2011. And it looks like Mr. Dulberg first came to see you on February 27th of 2012?

A. Yes.

Q. And he was referred to you by a Dr. Frank Sek; is that correct?

A. I'm not sure. Dr. Sek was the addressee of my correspondence from the first office note.

Q. Do you know what kind of doctor Dr. Sek is? Is he an internist?

A. I don't know. But Mr. Dulberg had been to my office before that when he had treatment in 2003 and 2004.

Q. Right. Let's talk a little bit about that 2003 and 2004 treatment. What did he come to your office for generally?

A. He came for a left arm condition of cubital tunnel syndrome.

Q. And what is cubital tunnel syndrome?

A. Ulnar nerve dysfunction due to compression at the elbow.

Q. And what is the ulnar nerve?

A. The ulnar nerve is one of the main peripheral nerves in the arm that passes behind the elbow in a region called the cubital tunnel before it extends down to the inner side of the hand to provide sensation and motor function to the muscles.

Q. Generally what were Mr. Dulberg's complaints in relation to his left arm when he came to see you back in 2003, 2004?

A. Numbness and tingling in the ulnar nerve distribution of the left hand.

Q. And what is the ulnar nerve distribution of the left hand?

A. The inside of the hand, the ring and small fingers especially.

Q. And is there an indication from those records from 2003 and 2004 as far as the onset or triggering event for those symptoms that Mr. Dulberg complained of back then?

A. He said it was following a motor vehicle accident which occurred in March of 2002.

Q. Did he describe to you at all how that accident happened or explain any type of the mechanism of that particular injury or those symptoms that he was claiming?

A. I don't recall, and those are not reflected in my notes.

Q. And what would be some common causes of cubital tunnel syndrome?

A. Well, the cause is compression on the nerve which may arise spontaneously. But there are some other factors that can contribute to it or cause it such as a direct injury to the vicinity of the nerve, or sometimes strenuous manual activities can contribute to the nerve compression.

Q. Can repetitive use -- typing, using the computer, using a mouse, anything like that -- can that cause cubital tunnel syndrome?

A. No, I wouldn't think so; not those type of sedentary activities.

Q. When you said a direct impact to the vicinity of the nerve, where are we talking about? We're talking about over the

elbow?

A. Yeah. It's the inner side of the elbow, toward the back where the nerve runs behind the joint.

Q. And you performed a couple of procedures to correct that cubital tunnel syndrome on Mr. Dulberg back then?

A. Yes.

Q. And were those procedures successful as far as you know?

A. I think so.

Q. So now when he first came to see you in February of 2012, what did he come to see you for?

A. For a right arm laceration of the forearm from a chain saw accident which occurred June 28, 2011.

Q. Did he tell you at all or give you any description of how this chain saw accident occurred?

A. No, not specifically.

Q. And I'm looking -- I'm referring to your February 29th letter to Dr. Sek. Mr. Dulberg indicates that he developed symptoms

of numbness in the small finger with weakness; is that correct?

A. Yes.

Q. Is there any indication as to when those symptoms started? Was it something that was immediate? Did it take some time?

A. I don't know.

Q. Did Mr. Dulberg ever provide you with any records from the emergency room shortly following this particular accident or did your office ever obtain any?

A. No, I don't believe so.

Q. His past medical history indicates remarkable for arthritis and cervical disc disease. Is the arthritis, would that have been located in the neck?

A. I don't know. He didn't specify.

Q. He was on some medications when he first came to see you?

A. Actually, he did specify degenerative discs in the neck. And the medications were naproxen, paroxetine, tramadol, cyclobenzaprine.

Q. Did he ever indicate to you that

he ever experienced any symptoms relating to the degenerative disc disease in his neck?

A. Well, he said he had neck pain on the health information form that he filled out that day I first saw him.

Q. He didn't go into any more detail about that?

A. No.

Q. The medications, naproxen, what is that for or what is that medication?

A. That's an anti-inflammatory medication used for typically pain symptoms related to inflammation.

Q. And how about tramadol?

A. That's another type of analgesic pain medicine.

Q. And fluoxetine?

A. I don't know. He indicated that it was for depression.

Q. And cyclobenzaprine?

A. He said it was for muscle spasms.

Q. Now, you performed an examination when Mr. Dulberg first came to see you; is that right?

A. Yes.

Q. And what were the results of that examination?

A. The right forearm showed a 7 centimeter transverse scar at the ulnar aspect of the mid forearm.

Q. And what area are we talking about there?

A. The inner side of the forearm between the elbow and the wrist. There was local tenderness and sensitivity to percussion with a positive Tinel's sign and paresthesias radiating into the small finger.

Q. What is a positive Tinel's sign?

A. Tapping or percussion over a peripheral nerve will elicit symptoms of sensitivity or shooting pain or electric shocks indicating nerve injury or nerve dysfunction.

Q. Is that a subjective or an objective finding?

A. Subjective.

Q. And then going on with his examination?

A. There was also sensitivity of the cubital tunnel region.

Q. And we're talking about on the right side; is that correct?

A. Yes.

Q. And you already talked about when he came to see you previously in 2003, 2004 about the cubital tunnel region of his left arm; is that correct?

A. Yes.

Q. And as far as --

A. I'm sorry, you said about the left arm?

Q. Right. Well, when he came to see you previously it was for the left?

A. Correct.

Q. And when he came to see you here it's for the right?

A. Correct.

Q. And then we get into wrist and elbow motion are unrestricted?

A. Yes.

Q. And then going on with his examination?

A. There was no atrophy. He was unable to adduct his small finger.

Q. What does that mean?

A. Bring the small finger closer to the other fingers, draw it back in. Flexion strength was grossly normal. Sensation was decreased to light touch in the small finger only with inconsistent two point discrimination.

Q. What does that mean, inconsistent two point discrimination?

A. His ability to sense one or two points on the fingertip was not consistently correct.

Q. You reviewed X-rays that were taken of his right forearm?

A. Yes.

Q. Did you review the films themselves or just the radiologist's report or both?

A. I think the films.

Q. And those appeared to be normal --

A. Yes.

Q. -- as far as fracture or anything

like that?

A. There was no fracture or foreign body.

Q. And then there was an MRI that you reviewed from February 3rd of 2012?

A. Yes.

Q. And again, would that have been the film or the radiologist's report or both?

A. The films.

Q. And that indicates that no abnormality was seen; is that correct?

A. Yes. I think I also have copies of the report of the MRI in my file, although I didn't refer to that specifically in the report.

Q. Right.

MR. BARCH: Yeah, it did come in your records.

BY MR. ACCARDO:

Q. And if I could just look -- if I could refer you to the report of the MRI, under clinical history he gives complaints or a reason why this particular MRI was taken was weakness in the fourth and fifth fingers,

is that correct, under clinical history?

A. Yes.

Q. And which are the fourth and fifth fingers?

A. I think the ring and small fingers.

Q. And also he was indicating pain in the forearm and hand?

A. Yes.

Q. And I know that the MRI came back normal. But under impression, I just wanted to ask you a couple of questions. It says that there's no forearm abnormality appreciated, but this does not exclude the possibility of an ulnar nerve impingement or injury, but there is no gross mass or abnormal infiltration along the expected course of the ulnar nerve. What does that mean?

A. Well, nothing abnormal was appreciated on these images. And I think the radiologist is saying that the lack of an imaging abnormality does not exclude the possibility that the nerve could have been

injured.

Q. Then it goes on to state that there was no obvious tendon or muscle abnormality appreciated.

A. Yes.

Q. And it looks like your office received a copy of a nerve conduction report or nerve conduction study that was performed by Dr. Levin back in -- on August 10th of 2011? I have a copy of it if you want to take a look at it. It came in your records.

A. Oh, yes, I have it.

Q. Oh, okay.

A. This is a different exam here.

MR. BARCH: Is this March 13 of '12?

MR. ACCARDO: Oh, I'm sorry. That's the later one.

THE WITNESS: There's two.

BY MR. ACCARDO:

Q. Yes. You have both, right?

A. Yes.

Q. From August 10, 2011 and March 13, 2012?

A. Yes.

Q. All right. Let's talk about that August 10, 2011. You reviewed a copy of that report from Dr. Levin?

A. Yes.

Q. And what did that indicate?

A. No electrophysiologic evidence of diffuse neuropathy.

Q. Is that significant to you at all?

A. Yes.

Q. How so? Obviously it's a negative finding?

A. Yeah. Diffuse neuropathy would possibly be a contributing cause of nerve symptoms if it was present, but this report states that it's not present.

Q. And sort of going back to when we asked you that question about, under the impression in the MRI report, about not excluding the possibility of an ulnar nerve impingement or injury, does that -- do the results from the nerve conduction study from August 10, 2011 sort of rule that out? Does that sort of take care of that little caveat,

if you know what I mean?

A. Well, I don't think it rules it out either. I felt that additional testing was warranted to evaluate the possibility of nerve injury.

Q. Now, after taking the history and your examination and your review of the radiological studies as well as the nerve conduction study, you came up with an impression back in February of 2012?

A. Yes.

Q. And what was that impression?

A. Right forearm laceration with probable partial ulnar nerve injury.

Q. And what indications led you to come up with the impression of a probable partial ulnar nerve injury?

A. Well, he had a scar over the region of the forearm where the ulnar nerve travels. He said it was a deep laceration, so there's a possibility that the nerve was directly injured by the chain saw. And that he had symptoms of paresthesias, numbness and weakness, that could be attributable to an

ulnar nerve injury. There were findings on examination of local sensitivity and altered sensation in the distribution of the ulnar nerve that again suggests the possibility of a nerve injury.

Q. And your plan was, I think as you said before, was to send him out for some additional testing?

A. Yes.

Q. And specifically, you wanted him to go get an EMG?

A. Yes.

Q. Now, what's the difference -- he had the nerve conduction study from Dr. Levin. What's the difference between a nerve conduction study and an EMG?

A. Well, an EMG is electromyography, where the muscles are tested for signs of denervation that would indicate a nerve injury.

Q. As opposed to a nerve conduction study which is what?

A. Yes. A nerve conduction study measures the velocity of the nerve impulses

which is another way of detecting signs of a nerve injury.

Q. Why was it then that you wanted him to have an EMG if he had already had a nerve conduction study? Just because they measure two different things?

A. Yes. I think for a more complete assessment of the nerve function, an EMG in my opinion is warranted.

Q. And you first brought up the possibility of a surgery for nerve exploration pending the results of the EMG; is that correct?

A. Yes.

Q. What is nerve exploration surgery? I'm guessing it's somewhat self-explanatory, but in layman's terms if you could just sort of explain what you were talking about there.

A. A surgical procedure under anesthesia to expose the area of the presumed nerve injury to determine the extent of the injury and the need for nerve repair or other treatment if the nerve injury is confirmed.

Q. And he indicated that he would

follow up with his EMG and actually go get that; is that correct?

A. Yes.

Q. Now, you also have work status is no restriction. Did Mr. Dulberg give you any indication or do you know what he was doing for a living back in February of 2012?

A. He said he was involved in graphic design printing.

Q. Did he ever make any complaints or indicate to you that he was unable to perform his job duties back in February of 2012?

A. I don't recall.

Q. So Mr. Dulberg did go have the EMG; is that correct?

A. Yes.

Q. And he went back to Dr. Levin who was the doctor that had performed the previous nerve conduction study?

A. Yes.

Q. And it looks like that EMG was done on March 13th of 2012?

A. Yes.

Q. And then he came back to see you

on April 2nd of 2012?

A. Yes.

Q. And he indicated there was no change in his symptoms at that time?

A. Yes.

Q. And you reviewed the report of the EMG?

A. Yes.

Q. And what did that show?

A. There was no denervation and ulnar nerve conduction was within normal limits. And the report states there was no evidence of focal or diffuse peripheral neuropathy.

Q. And is that significant to you?

A. Yes.

Q. Why or how so?

A. It means that there's no documentation that the nerve was not functioning normally.

Q. And you performed an examination again of Mr. Dulberg --

A. Yes.

Q. -- in April?

A. Yes.

Q. His right forearm scar was stable and non-tender?

A. Yes.

Q. And he still had a positive Tinel's sign?

A. Yes.

Q. And you indicate that adduction of the small finger remains limited, consistent with a positive Wartenberg's sign. What is Wartenberg's sign?

A. The patient will have difficulty bringing the small finger back toward the other fingers, indicating weakness in one of the intrinsic muscles of the hand.

Q. And again, this sensitivity to percussion with a positive Tinel's sign and adduction of the small finger with a positive Wartenberg's sign, are those subjective or objective findings?

A. Well, Tinel's sign is purely subjective. The Wartenberg's sign, I suppose there's a voluntary component possibly, so I don't know if I would call it purely objective. I don't know how to answer that

exactly.

Q. Okay.

A. I suppose it's partly both.

Q. And your plan was -- you gave him some different treatment options, and he did not wish to pursue that exploratory surgery; is that correct?

A. Yes.

Q. At least at that time?

A. Yes.

Q. You gave him a referral out for some therapy?

A. Yes.

Q. For strengthening and scar management. What is scar management?

A. Treatment for a sensitive scar from an injury. Maybe local soft tissue modalities being applied to the scar directly or scar mobilization with massage and stretching, those type of things.

Q. Would that be sort of just to loosen up whatever scar tissue there is in that area?

A. I suppose. Loosen up and diminish

sensitivity, discomfort or abnormal sensation related to the scar.

Q. And again, his activity and work status was unrestricted?

A. Yes.

Q. He came back to see you to follow up in May of 2012?

A. Yes.

Q. And his complaints at that time were a little different than they had been previously?

A. Yes.

Q. How were they different?

A. He said he had persistent pain with use of his arm, especially gripping activities.

Q. That was something new to you?

A. Well, I didn't note that earlier. I don't know if he said it earlier or not, but it's not in my notes that way. He also had no change in other symptoms of numbness.

Q. And he indicated that the no change in his symptoms of numbness which is not bothersome?

A. Yes.

Q. And as far as the way that's written, would that indicate to you that his symptoms of numbness were not bothersome to him at that time?

A. Yes.

Q. And he claimed that his function was limited because of this pain?

A. Yes. That seems to be a new complaint compared to the initial evaluation.

Q. And upon examination, what were your significant findings, if any?

A. The right forearm scar was tender with positive Tinel's sign, local sensitivity. His finger flexion was full. There was no triggering or locking, no clawing. The Wartenberg's sign was still positive. The intrinsic strength was slightly weak.

Q. What is intrinsic strength?

A. Strength of the muscles in the hand that control movement of the fingers.

Q. And how is that measured?

A. With resistance by the examiner.

Q. And you said that there was no --

A. I mean, it can't be graded numerically, but a judgment is made about whether the strength of the muscles is normal or weak.

Q. During that, is there any comparison made between a patient's left and right sides, whatever side they're complaining of versus, I guess for lack of a better term, a normal side or an asymptomatic side?

A. Yes. You can judge whether one hand is weak when you compare it to the other side being examined simultaneously.

Q. And you indicate no clawing. What is clawing?

A. An abnormal posture of the finger related to muscle weakness or muscle imbalance which can be seen in an ulnar nerve injury situation.

Q. And under your treatment plan you bring up again the possibility of surgery --

A. Yes.

Q. -- for ulnar nerve neurolysis.

What is that?

A. Neurolysis is an exploration of a nerve, surgical exploration of the nerve to determine the extent of injury to the nerve, possibly decompress the nerve or release it from scar.

Q. And he was going to follow up with Dr. Levin for medication, and then he was also going to see Dr. -- how do you pronounce his name?

A. Dr. Biafora is my partner.

Q. Does he have the same specialty as you?

A. Yes.

Q. Why was it that he wanted to go see him? Or did you send him to the other doctor for a second opinion?

A. I think I possibly suggested it, yes.

Q. And again, his activity and work status as of May of 2012 was still unrestricted?

A. Yes.

Q. And he did go see your partner a

few days later in May of 2012?

A. Yes.

Q. And did you have a chance to review Dr. Biafora's report?

A. Yes.

Q. Was there anything significant to you in there? Was there anything different than what you had found?

A. Yes.

Q. And what was that?

A. He noted a positive Tinel's at the cubital tunnel.

Q. Why is that significant to you?

A. That's another potential location for compression or dysfunction of the ulnar nerve.

Q. Which would also explain the symptoms that Mr. Dulberg was complaining of to you?

A. Some of them. It wouldn't explain scar symptoms at a more distal location, but it may explain nerve symptoms in the ulnar nerve distribution of the hand.

Q. And what were Dr. Biafora's

recommendations?

A. He thought there was a likely partial ulnar nerve injury in the right forearm and ulnar nerve neuritis. And he felt the patient may benefit from an ulnar nerve exploration with neurolysis, including cubital tunnel decompression with possible anterior transposition, and exploration of the tender portion of the scar in the forearm.

Q. And then Mr. Dulberg follows up with you after his visit with Dr. Biafora?

A. Yes.

Q. It looks like he had started on some medication from Dr. Levin?

A. Yes.

Q. And what was that that he started on?

A. Neurontin.

Q. And what is that?

A. Medication used to treat nerve related pain.

Q. Have you used that drug to treat nerve related pain in your patients?

A. Well, I don't prescribe it myself, but I've had patients who were prescribed that medication by other physicians to treat nerve related pain.

Q. Why is it that you don't prescribe it yourself?

A. Well, there's a potential for side effects, and sometimes the dose has to be adjusted. And I think it's best prescribed by a physician with more expertise in that particular drug.

Q. Would a doctor with more expertise be Dr. Levin?

A. Yes, a neurologist.

Q. He did indicate no change in his symptoms despite taking this medication and that he did have some side effects. Did he tell you what those side effects were?

A. I don't recall.

Q. And indicates that interfere with functioning. Did he tell you what kind of functioning that he was talking about?

A. I don't recall. That medication can cause some drowsiness. I don't know if

that's what he was referring to. I don't have any recollection of this conversation.

Q. So it's not necessarily, as far as you recall or would know, specifically related to having functioning difficulties with his hand or his arm?

A. I don't know.

Q. And Mr. Dulberg had then made the decision to go ahead with the surgery?

A. Yes.

Q. Now, he had been undergoing some therapy which in June of 2012 he said was discontinued due to lack of progress. Was that therapy that you had referred him out for?

A. I think at one point I had referred him for therapy. I don't know if anybody else had as well. We do have some records from the therapist. I see one from April 22, 2013 that has me listed as the referring physician. And it says discontinue occupational therapy with home exercise program.

Q. That was in April of 2013?

A. Yes.

Q. Who was that from, what therapy?

A. Dynamic Hand Therapy.

Q. I was just sort of interested because, going back to your note from May 14th of 2012, he indicated that the therapy was beneficial, and then in June of 2012 he indicates that it was discontinued due to lack of progress. I just didn't know whether your notes reflected or if you had any of the notes from any physical therapy showing any lessening of effectiveness or anything between May of 2012 and June of 2012.

A. I don't have those in my file. They may have been received and discarded. I don't know.

Q. And your examination of Mr. Dulberg on June 6th of 2012 revealed what that was significant?

A. He had pain with gripping activities localized to the forearm region, resulting in increased numbness in the ring and small fingers with weakness of his grip.

The rest of it was I think unchanged from what we had previously documented.

Q. And you were able to duplicate the positive Tinel's sign at the cubital tunnel area?

A. Yes.

Q. And it says without ulnar nerve subluxation. What does that mean?

A. The nerve did not subluxate or move out of position when the elbow was bent. So the nerve was stable.

Q. You went over your plan for surgery with him, he said everything was good to go with that, is that right, insofar as he wanted to have the procedure done?

A. Yes. I think he wanted to proceed, and he understood the risks and benefits and possible complications and the expected outcome and the prognosis. And informed consent was obtained for the procedure.

Q. Now, you note the prognosis is guarded in terms of symptom improvement. Why is that or why was that at that time?

A. Well, we didn't know exactly how much improvement there would be, so that's why the prognosis is guarded. It's hard to predict how much better the symptoms will be when we don't know the extent of the nerve injury until we explore it. So we just couldn't make a firm prognosis without knowing the extent of the nerve injury and how it would respond to the surgical treatment.

Q. And he did have the procedure then on July 9th of 2012?

A. Yes.

Q. And you performed that surgery?

A. Me and Dr. Biafora.

Q. Biafora, okay. Sorry if I'm mispronouncing his name.

A. I'll tell him.

Q. Your preoperative diagnosis and postoperative diagnoses were the same; is that correct?

A. Yes.

Q. As far as under what circumstances the procedure was performed, is that under

general anesthesia, local anesthesia, inpatient, outpatient?

A. I think it was outpatient surgery under regional block anesthetic which would also include sedation.

Q. Would he have been under at that time or more like in like twilight? He wouldn't have been all the way under.

A. Not a general anesthetic, but he would have been sedated which you might refer to as twilight. And his arm was blocked with local anesthetic so that it was numb during the procedure.

Q. And what were your findings? Now, there were a couple of components to this procedure; is that correct?

A. Two, yes.

Q. One was to the right elbow region which would have been the cubital tunnel release; is that correct?

A. Yes.

Q. And the other one was in regards to the area of the right forearm; is that correct?

A. Yes.

Q. In regards to the cubital tunnel area, what procedure and what findings did you come up with during that?

A. Cubital tunnel release was performed and there was thickening of the cubital tunnel ligament with scarring of the ulnar nerve to the floor of the cubital tunnel and local constriction. The nerve also appeared constricted at the flexor pronator aponeurosis. And there was another structure above the cubital tunnel but no constriction of the nerve at that level.

Q. What does all of that mean in layman's terms?

A. That he had a pinched nerve at the elbow.

Q. Is that similar to the findings in regards to his left arm back in 2003, 2004?

A. I don't have the operative report in the records here from that procedure, so I can't tell you the specific findings that were noted.

Q. The findings at least in your

operative report from July of 2012 in regards to the cubital tunnel, are those consistent with cubital tunnel syndrome? Is that sort of what we're talking about?

A. Yes.

Q. And we had already talked about some common causes of cubital tunnel syndrome before?

A. Yes.

Q. In regards to the area where the injury was -- strike that.

In regards to the right forearm, what did you find?

A. There was extension of the laceration into the subcutaneous tissues and fascia overlying the flexor carpi ulnaris muscle. A piece of retained absorbable suture material was present. The muscle fibers were intact. The ulnar nerve was intact beneath the muscle belly. There was no visible scarring around the ulnar nerve at this level.

Q. And again, in layman's terms, what does that mean?

A. It means that the laceration from the chain saw was relatively deep -- below the skin, below the fat, and into the muscle covering -- but the muscle fibers were intact. There was a suture material present presumably from when the laceration was originally repaired at the time of the injury. And the nerve was not cut or visibly scarred in that area.

Q. Was that, what you found during the procedure in regards to the right forearm, is that significant to you at all either one way or the other in regards to the complaints that Mr. Dulberg had made before the surgery.

A. Yes, it's significant.

Q. How so or why?

A. Well, I think that scarring from the laceration would account for his symptoms. And fortunately, the nerve itself was not cut or scarred and we didn't have to repair the nerve, so that was fortunate.

Q. How would it be that the scarring from the laceration would cause his symptoms?

What exactly would have been happening there?

A. Well, it's hard to know specifically what the mechanism of the pain symptoms and nerve symptoms was. We can't be sure what's causing those symptoms, although there's certainly scarring from the laceration involving the muscle, fascia, and near the nerve. So I think that's about all we can say in terms of an explanation for his symptoms.

Q. How about what you found in regards to his cubital tunnel syndrome in relation to the complaints that he was making, could that also have been a cause?

A. Yes. I think the nerve compression could account for the symptoms of paresthesias, the numbness in that distribution of the ulnar nerve, and the weakness.

Q. And those are two independent findings or independent areas in regards to the cubital tunnel area and the right forearm; is that a fair statement?

A. Yes, two separate sites.

Q. Now, after the procedure you performed, he came back to see you for various follow-ups in July, August, and then October of 2012; is that correct?

A. Yes.

Q. And how was he progressing during that time in regards to his recovery from the procedure?

A. His pain was controlled. His incisions were clean. There was no infection. The incision healed, incisions healed. He was doing well. His arm felt better. His function had increased. His symptoms had improved.

Q. Did his symptoms completely resolve or were they just improved?

A. They did not resolve completely. But through August 27th it says that his progress -- he was making progress in therapy. His strength had increased. His function had improved. There was still some scar tenderness and soreness in the elbow.

Q. And was he put on any restrictions as far as use or work?

A. Yes.

Q. And what were those?

A. Initially he was off work after the surgery until July 30th. Then he was given restriction to limit activities requiring forceful gripping and avoid lifting, pushing and pulling with the right arm. And those restrictions were modified October 22, 2012 to be limited forceful gripping and limited lifting, pushing and pulling.

Q. Would he have been limited or were the limitations that you imposed on him, would they have been in any way related to any type of use of the computer, mouse, track pad, keyboard, anything like that?

A. No, those activities would not need to be avoided or restricted because they don't require forceful gripping, lifting, pushing or pulling.

Q. And it looks like then he started to -- or he came back and, starting in December of 2012 and thereafter, started making some complaints related to his left

arm; is that correct?

A. Yes.

Q. And did he indicate when those difficulties with his left arm started?

A. He said recent onset. Well, that was my report saying recent onset. I don't recall if he said exactly when it started.

Q. And what types of symptoms was he complaining of in his left arm?

A. There was tenderness to the lateral epicondyle and guarded range of motion. Pain at the end range of extension and pain reproduced with resisted wrist extension. So those were consistent with lateral epicondylitis.

Q. Which is what?

A. Degeneration of the tendon origin at the elbow.

Q. Is that in any way related to what people refer to as tennis elbow?

A. Yes, that's another term given to it.

Q. And what are some causes for that particular condition?

A. It's typically degenerative. It's wear and tear. The tendon fibers lose strength and pain symptoms can develop. There can also be injuries that precipitate symptoms like blunt trauma to the area or certain strenuous manual activities that can aggravate it and cause symptoms to arise.

Q. Can it result from somebody overcompensating in using one arm over the other?

A. Well, that's kind of a vague scenario, overcompensating. I think if that resulted in enough strain to the involved tendon, it could aggravate it and precipitate symptoms of it. Depends on what activities we're talking about.

Q. Starting in December and up to -- it looks like your last visit with him was in late August of 2013, were the complaints limited to the left side or was he also still making complaints of anything related to the right side?

A. Well, in March of this year he said that his right forearm was sore

intermittently and there was mild sensitivity at the forearm scar. And then most recently, in August of this year, he described intermittent right forearm muscle cramping with discomfort.

Q. Was that cramping with use or certain activities or was it just sort of coming out of nowhere or doesn't it indicate?

A. It doesn't say for sure, but I see a note that the patient's neurologist suspected possibly dystonia and suggested a referral for evaluation and medical treatment by a neurologist who specializes in that condition.

Q. Did you make any referrals out to any other medical care providers?

A. I see a note of referral to Dr. Kujawa, a neurologist.

Q. And that would have been done by a referral that you made?

A. Yes.

Q. And in regards to his complaints of left-sided problems beginning in December of 2012, what if any treatment did you

provide him and what was your impression? Or I guess that would sort of go vice versa. What was your impression and what if any treatment did you provide for him?

A. The impression was left lateral epicondylitis. We gave him a referral for therapy for epicondylitis protocol. We gave him activity and work restrictions to avoid aggravation of his symptoms. We gave him a local steroid injection in the left elbow with continuation of occupational therapy. And then as far as the last visit in August of this year, he was allowed to follow up as needed.

Q. Does your office, as far as you know, show any future appointments scheduled with Mr. Dulberg?

A. I don't know. I don't have that information available here in the file.

Q. Is that something we would be able to check?

A. Yeah. It would be on the computer in the office.

Q. I'm going to ask you some opinion

questions. I would just ask that any opinions you give be within a reasonable degree of medical and orthopedic surgical certainty. Fair enough?

A. Yes.

Q. Do you have an opinion regarding what if any injuries Mr. Dulberg suffered as a result of the incident with the chain saw back in June of 2011?

A. Yes.

Q. And what is that opinion or opinions?

A. A deep soft tissue laceration in the right forearm.

Q. And what if any treatment that you rendered was related to that particular injury?

A. The EMG test I ordered; the supervised occupational therapy before surgery; the second opinion visit by Dr. Biafora; the surgical procedure of July 9, 2012; and the postoperative therapy and the -- well, those are the treatments I believe were needed as a result of the accident.

Q. And your prognosis, at least as far as your last visit with him on August 26th of 2013, what would your prognosis be in relation to any injury that you believe he suffered as a result of the chain saw accident, the deep soft tissue laceration?

A. The prognosis would be for symptoms to remain stable, unless the patient gets treatment by another neurologist which is effective, which I don't know. So within certainty I can say that the prognosis for symptoms to remain unchanged is expected.

Q. Are you able -- do you have an opinion as to whether the cubital tunnel syndrome that you found in the surgery that you performed, is that in any way related to the incident with the chain saw?

A. I don't think so.

Q. Are you able to differentiate between symptoms that Mr. Dulberg was complaining of in relation to -- or comparing the cubital tunnel syndrome versus the deep soft tissue laceration in the right forearm?

A. Yes, to some degree.

Q. Could you tell me what those differences are? What symptoms would you attribute to which condition?

A. The forearm laceration would account for the symptoms of scar sensitivity, tenderness, pain with gripping. And the cubital tunnel syndrome would account for sensitivity at the cubital tunnel region and paresthesias in the ring and small fingers, numbness in the ring and small fingers.

Q. Was any of the treatment that you rendered to Mr. Dulberg directed specifically or in part to the cubital tunnel symptoms or syndrome?

A. Yes.

Q. What treatment was that?

A. The cubital tunnel release surgery and the therapy treatments directed at the scar related to that surgery and the elbow motion.

Q. Is there any overlap in the care that he -- or the care or the treatment that he received for the soft tissue laceration

from the chain saw and the cubital tunnel -- I know that the surgery was for both conditions. But as far as the therapy, is there overlap there?

A. Yes. I presume they would have treated both areas at the same time.

MR. ACCARDO: All right. I don't think I have anything else. Thank you, Doctor.

E X A M I N A T I O N

BY MR. BARCH:

Q. Doctor, Ron Barch again on behalf of the McGuires. I think Attorney Accardo covered almost everything I wanted to, which will expedite my questions. Just a couple things, though, in follow-up.

There were some questions earlier that Mr. Accardo had about the left elbow, the tennis elbow, we were referring to that, that he developed or he saw you for in 2013. And he was asking whether overcompensating, overcompensating use of the left arm due to problems with the right arm might cause that.

And I'm just going back. When you said -- I think you answered, it would be dependent on the activities that they're doing with the left elbow?

A. Yes.

Q. What about just like adult daily living activities, like getting dressed or doing dishes, just doing normal, everyday things? Or are you talking about something more specific like work related repetitive trauma, that type of thing?

A. Well, I think in order to have a bearing on causation it would have to be beyond ordinary arm use, because we know that the degenerative process affects the tendon origin over time anyway. So normal, everyday tasks or usage wouldn't be expected to cause that condition beyond the chance it would already occur.

Q. And then with respect to the laceration of the arm, you talked in detail in response to Mr. Accardo's questions about the symptoms he had before the exploratory surgery and after. Anything about the left

arm, having seen him post-op, that would render him totally disabled? The left arm meaning the laceration part of the injury.

A. The laceration was the right forearm.

Q. Excuse me. Let me start that question over.

I just need to find out whether or not you saw anything about the laceration to the right arm, the things you saw during surgery and then your observations of him and his complaints following the exploratory surgery of the forearm injury, the laceration, anything about that that you believe would have rendered him totally disabled?

A. What do you mean, totally disabled?

Q. Unable to work any job at all.

A. Well, for the time period after the surgery was performed, he was given a restriction to be off work. That was until July 30th of 2012. After that he was given restrictions to limit use of the right arm

related to that injury and that surgery. But restrictions and disability don't necessarily equate. So disability would depend on what his function was and what his capability was and what his opportunities were, I suppose.

Q. And so if I understand your testimony, with respect to -- are you talking about the elbow surgery or the forearm laceration that necessitated the restriction against pushing, pulling and lifting with the right arm?

A. Well, the restriction was given after the surgery which had two parts. Are you asking which part necessitated the restriction?

Q. And that's what I'm trying to get at. I know that there's two different areas that you focused on during the surgery; the laceration of the right forearm, which I believe you said did not actually cut or scar the nerve, correct? Having gone through that exploratory surgery, it does not appear that the chain saw severed, cut or scarred that ulnar nerve in the forearm where the

laceration was?

A. Correct.

Q. And then there was some -- and you described in detail how deep you believe it went, having done that exploratory surgery. And then there's obviously the left -- the right elbow surgery that you did. And I know that for a period of time there was overlapping therapy for the forearm, the right forearm, and then the right elbow. And at some point he's released from care and he stopped the physical therapy on the arm totally, correct?

A. Yes. He was allowed to continue home exercises as of October 22, 2012 and advance activities with use of his right arm as tolerated at that time.

Q. And he continued, though, if I understood your testimony in response to Mr. Accardo's question, I have the restriction on pushing, pulling and lifting with the right arm?

A. Limited gripping, lifting, pushing and pulling, yes.

Q. And what I'm trying to get at now is, is that because of the injury he had to the forearm, was it the cubital syndrome in the right elbow, is it both, if you're able to tell us, the ongoing restriction?

A. Well, from my examination at that time, his tenderness was at the forearm scar region and there was still some pain with gripping at that location. So I would attribute the need for those restrictions to the forearm injury as opposed to the cubital tunnel elbow condition.

Q. And then if I -- with respect to whether he's disabled as an ongoing basis from that point forward, it would be the -- he would be disabled only to the extent that he would have to accommodate those restrictions in any form of employment?

A. I suppose you'd have to accommodate for his function, for his -- the word I would use would be "impairment" as opposed to "restriction."

Q. You wouldn't want him to -- I guess if I'm understanding your restriction,

he would want to avoid work that would require pulling, pushing and lifting on a regular basis with the right arm?

A. To the extent that that causes his symptoms to become intolerable.

Q. And then finally, is there anything you saw at that time, in October when he was let go with those limitations, that rendered him incapable of working at all?

A. No. He said he was currently unemployed at that time and planned to pursue disability, but he was allowed to use his right arm as tolerated.

Q. And that's the confusing part for me. Did you see anything that you would have endorsed in terms of acquiring disability, total and complete disability?

A. I think disability can be total or partial and can depend on one's functional abilities. So I think his function could have been impaired to some degree. I don't think it would necessitate a total disability from any job, though. Is that what you're

asking?

Q. That's what I'm asking.

MR. BARCH: Thank you. That's all I have.

MR. LUMBER: Do you have anything further?

MR. ACCARDO: No.

E X A M I N A T I O N

BY MR. LUMBER:

Q. Doctor, I just have one question that I want to follow up with you. If I understood your testimony correctly, regarding the cubital tunnel procedure that was done on his elbow, you were asked whether or not in your opinion you felt that was related to the chain saw accident, and I believe your answer was that you didn't think so.

Can you just give me a little bit of basis as to why that -- why you feel that way? Mainly because, as we had stated before, there is -- trauma and whatnot can cause cubital tunnel syndrome I believe as

you had testified earlier. So can you just clarify that a little bit for me as to what your basis is for why you feel that was not related to the accident?

A. I think the zone of injury for the accident was relatively distant to the area of the cubital tunnel, in the forearm as opposed to the elbow. So trauma to the area of the elbow would be suspected as a potential cause for cubital tunnel if that occurred. But I think this laceration was too distal to affect the nerve at the level of the elbow.

On the other hand, even though it's not directly injuring the cubital tunnel, the need for that surgery which included the cubital tunnel arose after the accident which brought him to see me. So I suppose there's some relationship of the injury and the surgery that included the cubital tunnel, but I don't think the specific laceration injured the nerve in the area of the cubital tunnel.

MR. LUMBER: Okay. That's all I

have.

MR. ACCARDO: I don't have anything else.

FURTHER EXAMINATION

BY MR. BARCH:

Q. Would it be fair to describe it, your last comment, as being there's an overlap in terms of timing but not a direct connection in terms of the injury and the location of the elbow, in relation to the elbow?

A. Yeah. There's not a direct injury to the nerve at the level of the elbow. But the condition came to light potentially as a result of the evaluations we did for the laceration.

Q. Well, there was a period of time before you did the surgery where you were kind of struggling to figure out why he was having the paresthesia and grip weakness in the hand.

A. Yes. And I think the first time it was really brought up as a diagnosis was

when he saw my partner, Dr. Biafora, who it seems suggested that that was part of the cause of his ongoing symptoms.

Q. And that was borne out during surgery?

A. Yes.

Q. Thank you.

A. I think the findings there were borne out.

FURTHER EXAMINATION

BY MR. LUMBER:

Q. Just one last follow-up. Any chance that any of the cubital tunnel dysfunction or ailment could have been any type of byproduct from the injury from the forearm, meaning from the injury of the forearm somehow caused this later injury to the cubital tunnel area?

A. I just don't think the mechanism would -- that one incident would cause cubital tunnel.

MR. LUMBER: Okay. Gotcha.

MR. ACCARDO: I don't have

anything else. I think we're done. Signature? Waived or reserved?

THE WITNESS: I can waive the signature.

MR. ACCARDO: Thank you.

(DEPOSITION CONCLUDED AT 10:41 A.M.)

* * * * *

STATE OF ILLINOIS)
) SS:
COUNTY OF L A K E)

I, Jill S. Tiffany, CSR, Certified Shorthand Reporter, and a notary public in and for the County of Lake and State of Illinois, do hereby certify that DR. SCOTT SAGERMAN on October 15, 2013 was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth, and that the above deposition was recorded stenographically by me and transcribed by me.

I FURTHER CERTIFY that the foregoing transcript of said deposition is a true, correct, and complete transcript of the testimony given by the said witness at the time and place specified.

I FURTHER CERTIFY that I am not a relative or employee or attorney or employee of such attorney or counsel, or financially interested directly or indirectly in this action.

IN WITNESS WHEREOF, I have set my hand.

_____

Jill S. Tiffany
Certified Shorthand Reporter
Certificate No. 084-002807

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24