IN THE CIRCUIT COURT OF THE 17TH
JUDICIAL CIRCUIT, IN AND FOR
BROWARD COUNTY, FLORIDA
CASE NO.: 01005548/08

ALAN R. WRASE and DIANA L. WRASE, :
his wife, :
Plaintiffs, :
-vs- :
JAMES L. CIMERA, M.D., and JAMES L.:
CIMERA, M.D., P.A., and DICKENS, :
SCHNELL, PERRY GOLDBERG, THAKER, :
KRAMPAT, P.A., d/b/a MEDICAL :
NEUROLOGY HOLY CROSS HOSPITAL, :
INC. d/b/a HOLY CROSS HOSPITAL, :
Defendants. :

DEPOSITION OF: DR. STEVEN IRA BECKER, M.D.
FRIDAY, JANUARY 24, 2003

Q & A COURT REPORTING SERVICE
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Deposition of DR. STEVEN IRA BECKER, M.D., taken in the above-entitled matter before Maria L. Gigliuto, a Certified Shorthand Reporter (License No. XIO2086) and Notary Public of the State of New Jersey, taken at the offices of Dr. Steven Ira Becker, 33-00 Broadway, Suite 204, Fair Lawn, New Jersey, on Friday, January 24, 2003, commencing at 2:00.

A P P E A R A N C E S:

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I N D E X

E X H I B I T S

DR. STEVEN IRA BECKER, M.D.,
with offices at 33-00 Broadway, Suite 204, Fair Lawn, New Jersey, having been first duly sworn, is examined and testifies as follows:

EXAMINATION

BY MR. BERMAN:

Q. State your name, please.

A. Steven I. Becker, B-e-c-k-e-r.

Q. Your professional address?

A. 33-00 Broadway, Fair Lawn, New Jersey.

Q. And this is your office that we're at, correct?

A. That's correct.

Q. Now, I want to thank you, Doctor, for agreeing to do the deposition, in spite of the fact that you had not received the $2,000 which you had indicated was your minimum. Am I correct, sir, that before you generally do a deposition, you require payment in advance of a $2,000 deposition fee?

A. For depositions we set aside an afternoon, which is four hours, so that we're uninterrupted, and it's $500 an hour.

Q. But you require a minimum of four hours?

A. Yes, yes, we set aside either a morning or an afternoon; it's a four-hour period.

Q. And that leads me to my next question.

Your rates for deposition are what, sir?

A. $500 an hour. Review of charts are $400 an hour, and a day outside the office is $6,000.

Q. So, in other words, if you were to come to Florida, you would charge $6,000?

A. For the day, yes.

Q. For the day. Would the day start when you left, let's say, you left the night before?

A. No, it would start the day of. If I had come up the night before, I usually leave after the testimony, so it's for one day. If the day extends to two days of testimony, that's a different story.

Q. Now, at present, how many active cases do you have that you're acting as a

medical legal consultant?

A. I can't give you an exact number which are active. I've done cases for many years, I have cases I don't know if they're active or not. I have about two dozen cases where I'm pretty sure are active. Some of them date back many years.

Q. And the reason why some of them date back many years is you may have been consulted, but they just haven't reached the trial stage yet?

A. Either that, but I don't know whether they've moved forward, but we have not been instructed to throw away the chart. So they're in storage or whatever until they pop up again.

Q. Do you have a list of cases that you have testified in or reviewed indicating the names of the attorneys by whom you were retained, names of opposing counsel --

A. No.

Q. -- and dates of testimony?

A. No, I don't.

Q. Okay. Have you ever testified in a federal court?

A. Many years ago. And the list you're referring to would be old by several years.

Q. Do you have that list?

A. I would have to dig it up. The answer is, I don't know. It's been a while, but for federal court we had to do a list.

Q. You haven't testified in federal court for how long, sir?

A. I've never testified in federal court.

Q. Okay. Could you give me an approximation of the number of depositions you've given in the last five years?

A. I'm going to say, and it's just a guesstimate, maybe 45 to 50 in the past five years. I don't know. In the many years I know it's over 100, but that's over 18 years.

Q. That would be another question I'm going to ask you which is, when did you start doing medical legal work?

A. About 18, 19 years.

Q. Approximately how many trials have you testified in in the last five years?

A. Oh, I can't even give you five

years. I've known through my 18 years, 19 years, I've done about 50, low 50 trials. Not all of them are necessarily medical negligence. Majority are. But they're related to medical legal issues.

Q. Okay. You said the majority are medical negligence.

Approximately what percentage?

A. I would say of the times I've been in court, probably, I would say, about 90 percent.

Q. And just so that I understand you, you testified in the last 18 or 19 years in approximately 50 to 55 trials?

A. Thereabouts.

Q. Okay. And of those of the times that you've testified at trial, what percentage has been for patient or plaintiff, as opposed to a health care provider?

A. Trial testimony has been for plaintiffs. The times I've been in court. I've given deposition testimony, and that has been plaintiff and defense.

Q. What percentage of depositions you have given are plaintiffs or patients, as

opposed to for defendants or health care providers?

A. Again, that's a figure I can't really give you. I can only tell you of the active cases I review now, 25 percent are defendant work, 75 percent are plaintiff work. I've given both sided depositions throughout the years.

Q. Have you ever evaluated a case for a defense firm in Florida and, if so, who?

A. No, I can't recall in Florida. I have in other states. Florida, I may have, but I can't recall.

Q. What states are you licensed to practice medicine in?

A. New York and New Jersey.

Q. And I have to ask this question. Have you ever had your privileges suspended or revoked in any of your hospitals?

A. No.

Q. Have you ever had your license suspended or revoked in any state?

A. No.

Q. Have you ever had any disciplinary hearings of any kind?

A. Yes, in New Jersey I took a reprimand for doing nothing wrong, and it was sent to New York, and we went into an Appellate Division, they reviewed the consent order, and they agreed the consent order said there was no wrongdoing. The New York issue was, I did take a reprimand to have the agreement was to have x-ray techniques reviewed by our radiologist on a periodic basis.

Q. As part of the consent decree, did you acknowledge you had filed false statements for an application in privileges for New Jersey?

A. No, I acknowledged I made statements that were true and accurate as of the time.

Q. The consent order did not acknowledge you had filed false statements for an application in privileges for New Jersey?

A. It says I made the statements. We agreed we made the statements, the statements were correct at the time. These things were in court at the time, so what they claimed -- these were in court, and the decisions had not been made. These were court actions, yes,

there is an acknowledgment, not that they were wrong since, you know, it says clearly there was no wrongdoing, no liability, no violation, of statutes, standards or codes.

If I made a misstatement on that, I would have violated a code or a standard, it says that right in there, so if they acknowledge I didn't do that, then I didn't make a misstatement.

Q. My understanding is that in that consent decree you also acknowledge you did not talk about a fee dispute you had over some issues with some provider.

A. No. They claim that they made inquiries about fees. We answered all the inquiries, and these dated back eight years. They said an inquiry is an investigation, and we said no, it's not an investigation. And the judge, this was before a judge, said to him, if the IRS looks at you and sends an inquiry about your 1099, are you in violation, are you fraudulently doing your taxes, they said no. Well, the investigation and inquiry are two different animals. They inquired, I responded, heard nothing for years, and then they said we

have an investigation. And what they basically said was no, you didn't have an investigation.

Q. And then, to be fair, the consent decree was sent to New York?

A. Correct.

Q. And New York then instituted a proceeding, which I believe you -- where the Board of Professional Medicine revoked your license.

A. No. The Board of Professional Medicine looked at the consent order and said I had done something wrong; therefore, they had the right to inflict the punishment. The first punishment was a state suspension. They wanted to. It was never enacted and they went to an internal review board. You have no idea. We went into the internal review board, no, we don't agree with them. They should revoke his license and went up to the Appellate Division of the Supreme Court in New York.

Q. It's not the intermediate Appellate Court?

A. In a unanimous decision they said that there was no wrongdoing because -- you read that. If they annulled their decision,

made it non -- it doesn't exist, and enjoined them from ever bringing this up again and criticized them because they had done this before, which we didn't know they were going to do, that they should have never brought this up because this was unfair. And the other issue they brought up was there I had no right to appeal a decision.

Their other argument was I had no right to appeal a decision before they made a decision; in other words, I would have -- in other words, I would have had to inform them, and if I didn't like their decision, I would have appealed them. The court didn't find that funny.

MS. ROGERS: I wonder why.

Q. In any event, after there was a proceeding by the Board of Professional Medicine, you disputed what is known as Article 27, and that determination was reversed, and your license was in full force and effect?

A. No, there was an immediate stay. An immediate stay. That was immediate. So there was no interim period, that was immediate where I was allowed to practice. And the

reason I got an immediate stay, they looked at the thing, and the stay was not going to a permanent injunction against the state, until they finally filed the appeal. And the opinion was this number is annulled number one and two, this should never be brought up again, and number three that document that they said someone implies wrongdoing says quite the opposite; says there is no wrongdoing in that document and, therefore, any implication of wrongdoing is a misinterpretation of that document on Appellate Court decision.

Q. Right.

A. The long and short of it, the New York is gone.

New Jersey I have an opinion what I say is true, there is no wrongdoing in that opinion, and I stand by that there is no wrongdoing. Here we did take a reprimand for doing nothing wrong. We paid a fee for their expert, and there was something about x-rays.

Q. And then you, for a period of time, were required to read x-rays under supervision?

A. Wrong. No.

Q. At least that was what I read.

A. No, it says monitor/trainer, we would not accept a monitor, but a trainer who was or radiologist basically reviewed our techniques. There was no problem with the x-rays. It was techniques. He reviewed the x-rays over a year, report the report, and that was the end of it.

As a matter of fact, I had to do one x-ray to meet their requirement. We did a little bit more than we had to do. We no longer had our centers anymore by that time, so the x-rays we took were minimum.

Q. Was that dispute recording interpretation of x-rays or whatever?

A. Techniques.

Q. Techniques. That's fine.

A. They had no question about the medicine. No interpretation.

Q. Was that with regard to general surgery x-rays or vascular surgery x-rays?

A. No, it had nothing to do with x-rays. No, this was for emergency center. I took 11 x-rays of thousands, I took 11 x-rays. They looked at my 11. The other were doctors, and they found fault with every x-ray, but only

went after me, not the other guys that took the other x-rays.

MS. ROGERS: Let me just interpose an objection for the purpose of the record on extent now, I'm just going to object to its relevancy and the admissibility of this line of questions just for the record. Just for the record.

MR. BERMAN: That's fine.

Q. Doctor, the information that I have is that you have testified or been listed as reviewing cases in Michigan, West Virginia, Massachusetts, New York, Kansas, Pennsylvania, New Jersey, Ohio, Georgia, Illinois, Texas, Connecticut, North Carolina, Indiana, Utah, Missouri, Rhode Island, and I may have missed one or two.

And is that a fair statement?

A. Yeah, I'm not so sure about Rhode Island, but the others. Rhode Island maybe I've seen a case. I don't remember.

Q. Any other states that you reviewed matters where there are proceedings where you reviewed matters that I haven't mentioned?

A. Not that I can recall.

Q. Okay. And I think you said earlier that approximately 25 percent of your cases now are defense and 75 are plaintiff.

When did that change, if at all?

A. It became more defense over the past. I'm going to say two, three, four, five years. I got more defense work than I had before.

Q. Do you know the number of defense cases you've done over the last 18 or 19 years?

A. No, I don't. Right now of the active cases I have, I have about eight defense cases that are defense that I reviewed for the defense. So that brings it up to about, it's a third, but it's not an accurate number, but I have defense cases seem to hang around longer than plaintiff cases, so I have more defense cases than my general average, only because they're hanging around more. So if they ever get settled or whatever happens to them, that number will go down.

Q. What percentage of your income is derived from medical legal work?

A. Five to seven percent, depending on the year. That varies from year to year.

Q. What percentage of your time is spent on medical legal matters?

A. I can't give you time because I usually don't -- my day is not involved for medical legal except for when I do a deposition I have to set time aside. Most of the reading I do is in the evening, it's not part of professional time, it's no way to tell you how much time I spent on reading.

Q. Do you know how many depositions you gave last year?

A. I have no idea.

Q. Have you ever been sued for medical malpractice?

A. Yes, I've had eight suits over my 18 years. Three of them have never come to deposition. They disappeared. Two were settled, two we went into court, and one -- and we lost one in court.

Q. Where were these cases, were they in New York or New Jersey or both?

A. All New Jersey.

Q. And do you know the names of the cases that you settled?

A. One was Noche, N-o-c-h-e. And the

other one was Maybe, M-a-y-b-e, I think it is.

Q. And in what county were those?

A. I'm not sure. They were not in Bergen or Passaic. That, I know.

Q. The case that you lost at trial, where was that?

A. That was in Passaic County.

Q. What was the name of that case?

A. Chestnut.

Q. Chestnut?

A. Chestnut, like the chestnut. Pseudo memberous intero colitis that perforated at the level, and she eventually died.

Q. The cases that settled?

A. One was what postoperative lead that required a transfusion, and the other one was, it settled on inform consent, he claims he didn't know he was going to have scars.

Q. What percentage of your practice is general surgery, as opposed to vascular surgery?

A. About 80 percent is general surgery. 20 percent is vascular, and vascular is arterial and veins.

Q. I'm sorry?

A. Artery and veins.

Q. When you say "artery and veins," what do you mean?

A. Venous surgery is things like stripping, radio frequency closures. Arterial would be bypass, corroded bypass aortal femoral bypass work.

Q. What percentage of your vascular practice deals with endarterectomies?

A. Lately over the past two to three years I do two to three endarterectomies a year. Previously I did more, but it varies.

Q. What percentage of your vascular practice involves operating on stroke patients?

A. Most of the people I operated had what's called a TIA, which is what you referred to as a mini stroke or a rind reversible inter cerebral neurovascular deficit. They're like mini strokes, irreversible strokes. Most of the carotid work, either one of those. Usually full-blown prolonged strokes we don't get involved with, I don't get involved with carotid surgery.

Q. Why is that?

A. Because when they've already had a

full-blown stroke and have a complete loss, there is very little you can do. It doesn't help to revascularize them. In fact, it can make them worse.

Q. In what way can it make them worse?

A. If they've had a bleed, and you supply them with more blood, you can extend the stroke to a larger area. You only operate on people who have reversed neurological deficit and don't have major cerebrovascular vascular bleeds.

Q. Reperfusion syndrome?

A. Correct.

Q. What you're talking about is that the reperfusion syndrome?

A. Correct.

Q. And do you have an opinion as to whether Mr. Wrase in this case had a TIA or a rind?

A. He had a rind. The difference was the length of time it lasts. A TIA is usually within 24 hours you reverse. A rind is longer.

Q. And I'm sorry, I didn't hear you before, a rind is a reversible what?

A. Intercerebral neurological deficit.

Q. How does one diagnose a rind as opposed to a stroke?

A. Well, they all are strokes. They all are strokes. The difference is the length of time and the reversibility. There is a stroke which is nonreversible total loss. No return in a short period of time. What I mean by that is one you are left with total hemo paralysis, you have no significant improvement. You have a TIA, which is a stroke, but it reverses very rapidly, usually 24 hours that's reversible. A rind is in between the two, it reverses over a period of time shorter than a month, but it's reversed. Most of that is a reversement of rind.

Q. What is the basis for your determination that Mr. Wrase had a rind?

A. He regained 99 percent of his neurological function rapidly and was left with some speech impediment.

Q. Can you cite to me where in the records there is an indication that he regained 99 percent of his neurological function and, if so, what is it?

A. Somewhere in there someone made a

comment that he regained 99 percent of his function. It's in a note of 6/4/99, Dr. Carcasco, he basically regained 99 percent of his strength. And there were further notes, "Speech therapy." He had some speech residual impediment that he was being treated for, but his strength basically came back.

Q. That's the note where he says that he wants to give him another two weeks of speech therapy?

A. Yeah, I believe it is.

Q. And when you talk about his strength came back, you're talking about his motor component?

A. Correct, motor function.

Q. And is there any indication as to whether he still had a sensory deficit in that note?

A. Well, when we talk about stroke, we talk about motor deficit, not sensory deficit. It's not relevant. Stroke would be.

Q. Do you know how Mr. Freidin's office got your name?

A. No.

Q. When were you first retained, sir?

A. I'm trying to see if I have the original letter. I don't see an original letter. It was a while ago. I don't have the original letter, so I can't give you a specific date, but it was a while ago. I don't have a specific date for you.

Q. Okay. Do you know what materials you were provided with?

A. Yes. I was originally provided with the medical. I have medical records related to the first stroke and second stroke. I also have medical records that don't relate to stroke at all. I have previous medical records, and I have received after that a deposition from Dr. Cimera.

Q. Okay. Have you reviewed the depositions of Dr. Sze or Dr. Levine?

A. No, I have not.

Q. How many operations on rinds a year do you do, sir, with regard to carotid arteries?

A. A limited amount I do now all have had TIAs. They've had mini strokes. Whether they've had a rind or not may be an arguable issue. TIA and a rind are very similar. All

of them have had a mini stroke. That's one of the criteria are they're referred to me, and once they've had a stroke, that's usually when I --

Q. So what you're telling me, though, in your experience and in your practice now with regard to carotid endarterectomy is exclusively with TIAs?

MS. ROGERS: Form.

A. No. In other words, most of the people I see now, as opposed to two years ago, we're dealing with HMOs, so they go to primary, so the primary sees them, and once they have a TIA, that's when they refer them out. Years ago you used to see them for stenosis and an evaluation. Now the evaluation is done by the primary, so he sees the evaluation, and then he does whatever he wants. Once he has the TIA, and they get worried, they send him to a vascular surgeon. That's how we get involved. Now the pattern has changed.

Q. What percentage of patients do you operate on now that have stenosis less than 50 percent of the carotid artery?

A. I have not operated on someone with

less than 50 percent in a long time. So recently none. All have over 50 percent stenosis.

Q. When was the last time you operated on somebody with less than 50 percent stenosis of the carotid artery?

A. Many years ago.

Q. Certainly it was before 1991, correct?

A. I can't say that with certainty, but there are other issues that get involved with the stenosis bilaterally and things like that. I have operated with less than 50 percent, but that's a rare end.

Q. Okay. With what frequency have you operated on patients with carotid stenosis of less than 50 percent?

A. Again, it's rare. I can't tell you how many.

Q. When you say "rare" --

A. Of all the carotid endarterectomies, most of them have had a stenosis of over 50 percent. Again, there are other factors, have they had a stroke, is it bilaterally involved, is it left side, right

side. There are other issues that get involved, but the majority of patients I've taken care of have over 50 when you're dealing with stenosis, over 50 percent.

Q. How many patients have you operated on with carotid endarterectomies that had ulcerated plaques only?

A. There are several over the years. Plaque is a different issue. Plaque has nothing to do with stenosis. Plaque you operate on.

Q. Every case, sir?

A. Symptomatic, every case.

Q. Every case?

A. Every case.

Q. Every case you operate on? Tell me a study that you can --

A. I can't state you a study on that.

Q. I know you can't Doctor.

How about with ulcerative plaque?

A. On ulcerative plaque, no.

On stenosis, over 50 percent. There are a lot of studies on that. Plaque, unfortunately, is a rarer entity, but the fact is plaque is more dangerous, the fact that it

causes a turbulence, and the people stroke out.

Q. The fact remains, sir, you cannot cite me one study that says that you operate on ulcerated plaque alone, can you?

A. I haven't done a review, so I can't tell you there isn't a study out there. I can't quote you one from the top of my head. But the fact is plaque is known to cause stroke due to the fact of the turbulence and the platelet aggregation.

Q. And how is platelet aggregation treated, sir? Tell me all the ways that you treat platelet aggregation.

MS. ROGERS: Form.

A. Aspirin and an anti platelet Flavic (ph) which is probably the more common one now, but they treat it with a medication, or they try to treat it with medication that prevents the platelets from adhering to one another. Aspirin being the main stay. They changed to other drugs over the years.

Q. Does not the literature indicate that as far as anti-platelet efficacy that aspirin and Flavic (ph) have the same degree of efficacy?

MS. ROGERS: Form.

A. Now you're quoting. There are so many studies. Not all the studies, particularly studies done by the drug companies, will not bear you out. That is the main stay, whether it works or not is the main issue. In stenosis that's the main treatment, anti-platelet and therapy aspirin being the main stay, and then they had an anti-platelet drug.

Q. Would you agree with me that with stenosis of less than 50 percent, aspirin is a recognized modality of anti-platelet therapy?

A. Yes.

Q. Now, when you first received materials, how were you contacted, did somebody call you, or did you just receive a package out of the blue?

A. I'm positive someone called me.

Q. Do you recall who that was?

A. No.

Q. Now, I know that you were going to speak with Mr. Freidin yesterday afternoon.

A. I did.

Q. How much time did you speak with

him?

A. About ten, 15 minutes.

Q. And I know you met with Ms. Rogers today.

How much time did you spend with her?

A. Before you came, about an hour.

Q. Before speaking with Mr. Freidin yesterday and Ms. Rogers today, had you ever spoken with any member of Mr. Freidin's firm before relative to issues in this case?

A. Yes, yes. I can't tell you who, but I have spoken on a periodic basis with Mr. Freidin. I believe I spoke to somebody else. Let me just correct one other thing. I did get a videotape of the testing at some point also.

Q. Of the carotid ultrasound?

A. Yes, yes, I did get this in the package, yeah, I did get it, it just crossed my mind, and I'm trying to remember conversations, what the conversation was about that, so, yes, I did get that.

(A discussion takes place off the record.)

Q. Doctor, you'll find, and you'll be

interested to know, that I try to be thorough. So I know that you were given the -- you just were nice enough to tell me you were given the carotid ultrasound, and I assume that was the carotid ultrasound of May 27th, it's either 1999 to 2000.

A. '99.

Q. And were you given the angiograms of July 12th, 2000?

A. I believe I had a report, I think I've seen a picture of one of the shots of the angiogram showing the ulceration.

Q. Did you review the actual angiogram or a copy of the angiogram itself?

A. No, I didn't do a full study of that.

Q. As part of your practice, do you regularly review angiograms?

A. On people I'm potentially operating on, yes.

Q. As part of your practice, though, do you not routinely interpret carotid ultrasounds?

A. That's not true. We do carotid ultrasounds in the office. I do read carotid

ultrasounds that are done in the office. Not done in the hospital, but in the office.

Q. You do not, though, issue a formal report on a normal carotid ultrasound done in a hospital, though, do you?

A. No, no.

Q. In the hospitals you practice at, who would review a carotid ultrasound normally would it be a neurologist, a radiologist, or both?

A. Radiologist.

Q. And again you would not be considered for a hospital base carotid ultrasound competent to render a formal report on that?

A. I wouldn't agree with incompetent. We don't do it because the radiology departments have done ultrasound, and every hospital I'm in they do it. I do have some training in vascular testing and ultrasound and in carotid, and I'm sure if I credentialed myself and they allowed us to do it, I'm sure I would be credentialed.

Q. You are not formally credentialed as of the present time; is that correct?

A. That's correct with the hospital, yes.

Q. Approximately -- have you issued -- strike that.

Have you issued a report in this case?

A. No, I have no written report.

Q. And approximately how many hours have you put into the case so far?

A. Six. I just, off the top of my head, six, seven. I don't have an exact number.

Q. And have you rendered any billing referable to the case so far?

A. Yes.

Q. Do you have that here?

A. I'm sure you can have it when you leave, whatever was done.

Q. Okay. Now, as part of the materials that we asked for in connection with this deposition -- do you have your entire file referable to this case?

A. Yes.

Q. Do you have it here?

A. Right in front of me.

Q. Good. And could you tell me any way you want to, give me a list of everything that you were provided with relative to this case.

A. As I explained, I have the deposition that we discussed, I have the videotape, I have medical records related to multiple hospitalizations. There are Holy Cross Hospital, there are ultrasounds, operative notes, there's again, the two hospitalizations of the stroke. I then have hospitalizations of things not related to the stroke which date back several years. Admissions in July of '96, which are unrelated issues. I'm trying to give you the hospital records I have.

Q. That's fine.

A. Things previous which don't relate to this and have no bearing on this, but which date back to, I think '96 is the most recent, because the past one I have, the rest are current. Like the '99 issue. So I have Holy Cross Hospital records through the hospitalizations, and then I have some earlier ones.

Q. Do you have all the correspondence from Mr. Freidin's office? You indicated you believe you didn't have the initial transmittal letter.

A. I have some letters here.

Q. Can I see?

A. Sure.

MS. ROGERS: Let me just go off the record for a second.

(A discussion takes place off the record.)

Q. Did you give a pre suit affidavit in this case?

A. You know, I'm not sure. I don't see it in my file here, but I may have. I don't know.

MS. ROGERS: But just so the record reflects the off the record discussion, it was related to the pre suit privilege.

MR. BERMAN: Right, right. I understand. And the objection is preserved.

MS. ROGERS: Thank you.

Q. Doctor, you've given me basically three letters dated January 10, 2003, July 10, 2002, and a notice of taking deposition duces

tecum.

Do you have any other correspondence from Mr. Freidin's office in your possession?

A. No, no, that's the only thing I have.

Q. What did you do with the transmittal letter initially that you don't have?

A. I don't know.

Q. Okay. Wait a minute. I think that notice is my notice. I'm sorry.

A. No, no.

Q. That's yours?

A. Yes.

Q. Did you do any literature search in connection with this case?

A. No, no.

Q. Did you make any notes?

A. No.

MS. ROGERS: We've got a CV here for you.

Q. I'll take a look at it if you don't mind.

A. No problem. It's here somewhere.

MR. BERMAN: Off the record.

(A discussion takes place off the record.)

A. Here's my CV.

Q. Thank you.

Do any of the publications listed on your curriculum vitae have any relevance to the issues in this case?

A. Some of the courses I've taken relate to vascular testing and vascular studies, and they relate to the case in the fact that --

MR. BERMAN: Do you need to take that?

MS. ROGERS: Yes.

MR. BERMAN: Let's stop for a second.

(A discussion takes place off the record.)

Q. Doctor, in regard to my last question, you indicated that some of the courses you've taken relate to the issues in this case.

Have you ever taught any courses that relate to the issues in this case?

A. No. Well, let me correct that. I did run the vascular lab at one of the hospitals. In the process we had residents that rotated through for non-evasive vascular testing. In that aspect I was a teaching at Saddle Brook Vascular Hospital. As they rotated through, they had to be educated in non-evasive vascular testing. So there was teaching non-evasive formal lecture series.

Q. As part of supervision of residents?

A. Correct.

Q. But that wasn't formal certifications of carotid ultrasounds?

A. No, no, that was registered and training.

MR. BERMAN: Off the record.

(A discussion takes place off the record.)

Q. Now, Doctor, what were you asked to do upon your retention?

A. Reviewed the medical records related to the stroke, the evaluation of the carotid artery, and eventual treatment and re stroke.

Q. I apologize. I have to write it now.

MS. ROGERS: And his opinions, Ken Morgan, are limited to Dr. Cimera.

MR. MORGAN: I appreciate that, Susan. I was unsure. I appreciate that.

Q. You were asked to do what?

A. Evaluate the medical records as related to the treatment of or evaluation of the carotid arteries and eventual re stroke and eventual surgery of the carotid arteries.

Q. What are the topics of the opinions that you intend to offer at trial?

A. First that after the first stroke patient's evaluation of his carotid artery was inadequate. The ultrasound was sub optimal, and no further investigation was done. And since the evaluation was not done appropriately, he was denied the opportunity of being treated, which would involve surgery and carotid endarterectomy, and the result of which he re stroked.

Q. So I take it you intend to offer opinions on standard of care and causation.

A. Correct.

Q. You're not a neurologist, are you?

A. Absolutely not.

Q. Now, you said in the first -- after the first stroke you believe that the work-up was inadequate.

A. Sub optimal, yes.

Q. What do you mean by the term "sub optimal"?

A. The carotid ultrasound is of very poor quality. It was not on the sounding, Doppler soundings. There was some suspicion in the internal carotid that was investigated. No MRI was done or arteriogram was done, and the ulcered plaque went undiagnosed, and the patient re stroked.

Q. What was the suspicion in the internal carotid artery that you're talking about?

A. First of all, the view of the internal carotid was definitely sub optimal. I would not have attempted to read that. I would have had it repeated on the Doppler soundings. There was a high pitch as soon as you leave the common carotid and go into the internal, there's a high pitch sounding, which is

indicative of turbulent flow, which is really a narrowing or a stenosis or a plaque or an ulcerative plaque. And when you look at the pictures of that area, it's very obscure, so you can't really see it. The definition there is not enough, and it should have been repeated. If it was still sub optimal, it should have had a further study. My preference being an MRA or an arteriogram. An MRA being safer to evaluate that area.

Q. Is a MRA designed to evaluate ulcerative plaques and stenosis?

A. Yes. And stenosis.

Q. Ulcerative plaques?

A. No. Angiography would be used.

Q. Angiography would be used to find?

A. Everything, emboli. Arteriogram is emboli, ulcerative plaques, stenosis, there are other abnormalities, but those are the main ones.

Q. Are you familiar -- strike that.

Is a Doppler ultrasound designed to diagnose ulcerative plaques?

A. Yes.

Q. In what way is a Doppler ultrasound

designed to diagnose ulcerative --

A. The ultrasound portion, the picture portion, can identify and visualize ultrapleuro plaque. The Doppler is a sounding which creates high-pitched soundwaves due to turbulent flow or disruption of flow. It can happen in stenosis, or it can happen in ulcerative plaque. It recites a turbulence or high-pitched sounding a Doppler, where we had ultrasound and found some abnormalities as to flow in that area this is the pinpoint where you can visualize the area, helps you visualize the area.

Q. Is an angiogram the best way to show stenosis or the degree of stenosis?

A. The best way to evaluate stenosis is an operation. The next best way, arteriogram is definitely excellent, definitely shows stenosis, as does an MRA, as does a digital sub traction angiography. They all will show stenosis.

Q. Are patients with any degree of stenosis routinely operated on with carotid and the endarterectomy?

MS. ROGERS: Form.

A. Any degree of stenosis?

Q. Yes.

A. No, no, that would be depending on symptoms. Symptoms would be very important. Asymptomatic the answer is no.

Q. Was Mr. Wrase a symptomatic or asymptomatic patient?

A. He was a symptomatic patient of an ulcerative plaque.

Q. How do you know that?

A. He was operated on. He had no stenosis confirmed at operation. He had an ulcerative plaque confirmed at operation. He had no stenosis that the ultrasound could see, and the arteriogram which was done did not show stenosis, it does show ulcerative plaque.

Q. Did the arteriogram show ulcerative plaque distal to the bifurcation of the carotid artery?

A. That was in the internal carotid after the bifurcation.

Q. It was distal to the bifurcation, correct?

A. Yes, it was in the interim report.

Q. How far?

A. I would have to have the x-rays to measure.

Q. But you've never done a measurement, have you?

A. No.

Q. On your review of the carotid ultrasound, did you see a stenosis in excess of 70 percent?

A. Again, on the ultrasound done, which was sub optimal, I couldn't say I did not see a stenosis on that, but that would be sub optimal. I would go by the Doppler soundings, which didn't suggest that, and the arteriogram, which definitely showed no stenosis.

Q. The arteriogram showed no stenosis or minimal stenosis?

A. Minimal maybe, but no significant, no 70 percent stenosis on the arteriogram.

Q. Can we agree, Doctor, that according to the literature, according to stenosis, one needs 70 percent stenosis to have a clear-cut indication for endarterectomy?

MS. ROGERS: Form.

Q. Just talking about stenosis now.

A. No, I don't agree with you.

MS. ROGERS: Form.

A. Articles vary. The one thing they do have is over 50 percent occludes the artery by 75 percent, if you have 50 percent stenosis that decreases because it circumferentially decreases flow rate by 70, 75 percent if the patient is symptomatic at that point what you're saying to me is not true. You would operate on them if they had an over 50 percent and symptomatic. If they were asymptomatic, then you normally would not operate on them under 15 percent.

Q. Can we agree there Mr. Wrase did not have stenosis in excess of 50 percent?

A. We can agree.

Q. Okay. I take it your position is that every ulcerative plaque should be operated on.

MS. ROGERS: Form.

A. Every ulcerated plaque, someone who is presented with symptoms which is a TIA, a mini stroke or a stroke, reversible stroke, and they have plaque, should be operated.

Q. Why?

A. Because if they don't, they re

stroke.

Q. In every case?

A. In a high number of cases.

MS. ROGERS: Form.

Q. In what number of cases?

A. 25 to 50 percent.

Q. With ulcerative plaque?

A. Untreated ulcerative plaque and stenosis which would be medications as high as 50 percent of stroke.

Q. Can you cite me to any study that gives those statistics?

A. I can't cite you a study because I haven't done a review, but I'm just telling you from my experience as a vascular surgeon, a vascular surgeon who sees stroke and ulcerative plaque operates on it.

Q. In every case?

A. Not every surgeon may do it properly, but every surgeon that I know who deals with ulcerative plaque and is part of my training and is symptomatic and a TIA or rind or stroke that is reversible in some manner or form that has an ulcerative plaque can be treated.

Q. Can we agree this patient did not have a cardiac source of emboli?

A. The cardiac source did not bear that. I see no likelihood that the emboli came from the heart.

Q. Can we agree there was no indication for Heparin?

MS. ROGERS: Form.

A. That's a hard question to answer, and I'm into other studies. There are studies that people would have heparinized in cases with ulcerative plaque and first stroke usually as an interim measure, and some would have even gone to Coumadin. There are studies that do, so I don't want to get into unless you really want to.

Q. I just want to know what your opinions are.

A. My opinion is that in certain cases Heparin is very helpful in this situation. Anticoagulation is a modality used in some cases.

Q. Is it your position that Heparin or Coumadin is more efficacious in this setting than aspirin?

A. No. It is very often used gingerly in conjunction with because we're in an area where even in the case of anti-platelet therapy people still have platelet coagulation and stroke and use that more as an interim measure.

MS. ROGERS: Let me just state something for the record.

MR. BERMAN: He has no opinion on it.

MS. ROGERS: It is my understanding Dr. Becker will be offering testimony initially to surgical management of this issue more than anything as opposed to Heparinizing (ph) and things that of point, I'm not going to opine that antibiotics in this case is anticoagulation.

Q. He doesn't have an opinion? Let me just get it straight.

Is it fair to say that you have no opinion on whether or not either Heparin or Coumadin should have been used with respect to this patient?

A. I have no opinion that there was any issue here with anticoagulation of any deviation in nature.

Q. On angiogram, what was the percentage of stenosis in your opinion in Mr. Wrase?

A. I would have to look at the --

MS. ROGERS: We know he said it was less than 50 percent.

MR. BERMAN: I know that, but I want to know if he can pin it down any more.

A. From what the arteriogram says, they use the word "significant." I don't know what their level of significant means, so you have to defer to them. They don't give me anything here other than -- they say plaque, which is not causing significant stenosis.

Q. They say there is plaque which is not causing significant stenosis?

A. Again you're asking the percentage of stenosis. In some cases you could say 50 percent is significant, but I think here from what I saw it's less than 50 percent, but he doesn't give a figure here.

Q. Did you come up with any figure on your own?

A. No.

Q. Do you intend to?

A. No.

Q. So in other words, it's less than 50 percent, but you can't quantify it any greater?

A. To me I'm just reading the word "significant." To me, in my opinion would be less than 50 percent, but that doesn't mean that's the number he chose to use for significant.

Q. Okay. Now, what's your definition of the term "ulcerative plaques"?

A. It is a plaque which is basically arterial sclerotic, which has a cavity, an indentation, a little pocket.

Q. Or an irregularity?

A. It's meant to mean a pocket. It has a cavity in it. That creates a whirlpool type of effect.

Q. And how does one prove an ulcerative plaque? I think you indicated MRA, angiogram.

A. Ultrasound, Doppler ultrasound, color Doppler, MRA, digital sub traction, arteriography and operation.

Q. Do you recognize any textbooks as

being authoritative?

A. Informative, yes; authoritative, no.

Q. Do you recognize any journals being authoritative, or studies?

A. No. Studies are mainly informative, and they change very, very radically.

Q. Has the NACET study been accepted by neurologists and vascular surgeons with regard to carotid and/or endarterectomies with regard to asymptomatic and symptomatic patients?

MS. ROGERS: Form.

A. It was basically more for asymptomatic patients following them over a period of many, many years. It does talk about both, but the answer is it's an informative study. It's not, I don't believe it's 100 percent. I don't believe it relates to a lot of people that become symptomatic. It mainly is an asymptomatic study over a long period of time with anti-platelet therapy. It's not the definitive study. It is one of the studies that have been done which is --

Q. What is the definitive studies?

A. As a matter of fact, studies that contradict the studies that we have are numerous.

Q. What studies, if any, contradict the studies of the NACET study?

A. Again I didn't do a literature search, but I'm sure I could find many.

Q. "Many" meaning how many?

A. More than two.

Q. "More than two" meaning how many, but you haven't bothered to do any?

MS. ROGERS: Form.

Q. When there is an ulcerative plaque, is there any criteria that you use to define the degree of ulceration that you would operate on?

A. No. Ulcerative plaque relates to -- is more related to symptomatology. If you have an ulcerative plaque and you have symptoms, in other words, the TIA or whatever, and you can find no other cause, credible cause, it's caused by the ulcerative plaque and should be removed.

Q. What are the ways in which one

determines whether or not there is another credible cause of the TIA, TIA or the rind or the stroke?

A. Well, by a process of elimination as you referred to, cardiac you want to make sure there's no mixnomer, you want to make sure the patient doesn't have arrythmias that would relate to embolic phenomena which you would treat for and then you evaluate the carotid. And you do it in a sequential study. It would be unlikely to have all the criteria at the same time. So if you found the one, you would operate on the it and the arrythmia, you would correct the arrhythmia and the anticoagulant.

Q. What do you mean by the term "mixnoma" (ph)?

A. Mixnoma is a tumor in the heart which is noted to produce emboli which can produce emboli to cause stroke and other things too.

Q. Can we agree, sir, that an important part of management decision is the degree of stenosis in the carotid artery?

MS. ROGERS: Form.

A. In what type of -- in this patient,

no. In other situations you have to give me the situation.

Q. Why is the degree of stenosis not an important part of the management decision with respect to this patient?

A. Because he had an ulcerative plaque, and his stroke was caused by the turbulent flow and platelet coagulation due to the ulcerative plaque, not due to stenosis.

Q. How do you know it was caused by the turbulent flow due to an ulcerative plaque in this case?

A. Because there are no other causes for it. The ulcerative plaque causes that, it's noted to cause that, and since you can find no other cause of it, it would, with reasonable medical probability, the ulcerative plaque was the cause of his stroke in the process of platelet coagulation. Since you cannot see it and you said so the heart has been eliminated, there is no stenotic process, there is no other process other than an ulcerative plaque.

Q. What percentage of strokes are caused by unknown origin, sir?

A. I can't give you that.

Q. But there are strokes that are caused by unknown origin?

A. Yes, yes, but I can't give you that.

Q. There are a significant percentage of strokes that are caused by unknown origin, are there not, sir?

MS. ROGERS: Form.

A. There are strokes where we may not be able to find the cause or hasn't been evaluated, but yes, there are cases of these people also have major, major other problems as well.

Q. I didn't mean to cut you off.

A. No, go ahead.

Q. Did not the NACET study specifically exclude ulcerative plaque?

MS. ROGERS: Form.

A. I don't remember that, quite frankly. I don't know if it included it or extruded it, but the fact of the matter is there are other studies that deal with ulcerative plaque other than the NACET study. I don't have it in front of me.

Q. Those are the studies that you can't cite me to, correct?

A. I haven't looked for them, but ulcerative plaque is a known entity.

Q. Is there any articles which state an asymptomatic ulcerative plaque without stenosis of greater than 70 percent should be operated on in all cases?

MS. ROGERS: Form.

A. Asymptomatic?

Q. Yes.

A. I don't know, sir, I haven't done research, so I don't know if there's a study out there that says that should be done.

Q. Is there any study that says you operate on a symptomatic ulcerative plaque without stenosis greater than 70 percent?

A. I can't --

Q. In all cases?

A. I can't quote the study because I haven't done a literature search, but that would be my training.

Q. And you're saying it's standard of care to operate on non-stenosising ulcerative plaque in all cases?

A. With symptoms.

Q. What are the symptoms that you're referring to?

A. Stroke.

Q. What kind of stroke symptoms?

A. TIA, rind, reversible strokes.

Q. You're talking about processes, you're not talking about symptoms. I want to know what symptoms you're talking about, sir.

A. The symptoms of a stroke can be numerous. They can be anywhere from weakness on one side to total paralysis on one side. There can be loss of vision involved with that, which is also called a mini stroke. There is on one side in this case speech impediment, and nothing else. You can have memory loss, you can have dizziness. And probably if I go through different strokes probably others given a long enough period of time I can figure these all can be a process of stroke. We use stroke as a one term, but stroke can mean many, many things, even loss of vision in one eye can be called a stroke.

Q. What symptoms did Mr. Wrase have?

A. He had a hemi paralysis, and he had

a speech impediment.

Q. And the speech impediment had not resolved as of the time of the second stroke, correct?

MS. ROGERS: Form. Overly broad.

A. It hadn't resolved, it had improved.

Q. It hadn't resolved?

MS. ROGERS: Form. Completely.

MR. BERMAN: Please don't make speaking objections.

MS. ROGERS: Sorry. Your question was misleading, so that was the basis of my former objection.

MR. BERMAN: You can do it on redirect.

MS. ROGERS: No, I don't need to redirect this guy.

Q. Now, what was the cause of the ulcerative plaque that this man suffered?

A. To a reasonable degree of medical probability, platelet aggregation and emboli.

Q. From where?

A. From the ulcerative plaque. And it went up the middle cerebral artery.

THE WITNESS: Excuse me.

(A discussion takes place off the record.)

Q. Doctor --

(Brief recess.)

MS. ROGERS: Are you there, Ken?

MR. MORGAN: Present.

Q. Doctor, is arterio sclerosis disease a potential cause of stroke?

A. It can be.

Q. Do you have an opinion on whether or not it was a potential cause of stroke in this case?

A. In this case I do not believe it was a cause of stroke.

Q. Why do you not believe that?

A. Because it was not specific.

Q. What degree of arteriosclerotic disease do you need to have to be a cause of stroke?

A. Depending which level vessel and what have you it adheres to greater than 50 percent rule in most of the arteries, and depending on where usually. This didn't exist here.

Q. Assuming that there is an arteriosclerotic disease here, is anti-platelet therapy alone a recognized modality of treatment assuming it's less than 50 percent?

MS. ROGERS: Form.

A. In many of the aortic arteriosclerotic disease it's not necessarily treated. Again, it's a hard question to answer, depending on where you're talking about and what have you. But is anti-platelet therapy used in certain cases of significant stenosis, yes, it's used.

Q. Also, if there is less than 50 percent stenosis, platelet therapy alone is used?

A. Again, less than 50 percent you're getting questionable. If it's asymptomatic and less than 50 percent, the majority would not be treated.

Q. Not treated operatively?

A. Not treated with anti-platelet therapy and aspirin and what have you.

Q. No treatment at all?

A. No treatment at all.

Q. I may have asked you this already,

but I just want to make sure. Can we agree that Mr. Wrase did not have a high grade carotid stenosis in excess of 70 percent?

A. Yes, we agreed.

Q. Okay.

MS. ROGERS: There's lots of red check marks going on there, Ken.

MR. MORGAN: That's that.

MS. ROGERS: Never mind.

Q. After a stroke occurs, can a second stroke occur with treatment?

A. Well, what do you mean by "treatment"?

Q. Assuming that one does a carotid endarterectomy after a first stroke --

A. Right.

Q. -- can there not be another stroke after that?

A. Postoperative strokes, and I'll answer it this way, postoperative strokes after surgery, depending on who you read, most material in this case decreases the interval of two percent. Decreases the interval of re stroke additionally it hits a stenosis or another vascular problem occurs without

treatment, the chance of stroke is very, very high. Re stroke is very high, and it's related to time. Within a year, it's as high as, I told you, 25 to 50 percent. If you go over that, it becomes higher.

Q. If it's under a year, what's the degree of re stroke or re stenosis?

A. 25 to 50 percent. Not re stenosis. Re stroke, not re stenosis. Re stroke, 25 to 50 percent will re stroke.

Q. That's without treatment?

A. That's re stroke in all. When you put them on anti-platelet therapy or not, they will re stroke in that period of time.

Q. With carotid endarterectomy?

A. No, no, we're talking about without. No treatment.

Q. That's what I want to make sure.

A. With carotid endarterectomy you increase the interval free stroke period, it goes down after you take the plaque out to almost a normal period of time it goes to about a five percent a year after stroke, but it's treated. If you decrease the stenosis and do an endarterectomy and decrease the stenosis

without re stenosis, if you re stenosis in a year, then your symptoms change. So there's a top, there is an issue of re stenosis which we can't get into here. As far as we know we're not dealing with re stenosis. There's certain people who re stenosis very rapidly, but that's not a common occurrence. So I'm just covering all bases when you say that.

If you have a normal carotid study first year, second year, third year, your instance of re stroke goes down every year, but it's about five percent it actually goes down as long as you don't re stenosis. If you re stenosis, the incidence goes up.

Q. With an ulcerative plaque that you have a recurrence of stroke, what is the mechanism by which the recurrence of stroke appears?

A. Well, most of the time the mechanism is against emboli, embolic phenomenon and platelet emboli, but that usually occurs when there's further disease of the valve.

Q. When you say further disease of the valve, what do you mean, sir?

A. It shows an ongoing period. An

endarterectomy does not stop arterial stenosis, it just removes the plaque or the narrowing. As you get older you can re stenosis, more plaque will form. There are people who re stenosis very rapidly, and there are people who take a long, long time to form plaque and re stenosis or develop another ulcerative plaque. If they don't develop a re stenosis, their chance of stroke is minimal.

Q. When we talk about re stenosis, are we talking about re stenosising of plaque?

A. Well, plaque causes stenosis. So all stenosis is due to alternate stenosis. I'm not talking about mechanical like a misoperation. In all stenosis we have a arterial sclerotic progressive disease. Because you do an endarterectomy, you don't stop the process of the disease, you only decrease the narrowing in that area. You can reform plaque there and re stenosis.

Q. Assuming there is a ulcerative plaque present and you do a carotid endarterectomy --

A. Right.

Q. -- can you reform additional

ulcerative plaque?

A. Over time, yes, you can.

Q. What is the degree of time it takes to reform ulcerative plaque?

A. Several years it can be. First you have to form plaque, and then it has to ulcerate. So it can be years.

Q. Can it be less than years?

MS. ROGERS: Form.

A. I would say reulceration of plaque can be at least over a year, and one exclusion there are people who re stenosis, which is another topic, very rapidly. We don't know why, but there are a certain number that you just clean out the artery, and within a year they've significantly re stenosed. We don't know why. It's a very small group. It does happen. We don't know why.

Q. We don't know why and who that will occur in?

A. Until they re stenosis you can't tell who those people will be, and you can't predict that, yes.

Q. So it's possible if a carotid endarterectomy were done with Mr. Wrase --

A. You can't restinose if you don't have stinosis.

Q. It's possible he could have reformed plaque within a year?

MS. ROGERS: Form.

A. Right. Re stenosis? A different issue. Re stenosis is a circumference re accumulation of plaque and reforming, it's not just a reformation of plaque, it's a certain entity that forms a circulation of plaque which narrows very rapidly again. Nobody knows why.

Q. I know that, and I appreciate it. What I'm asking you, is it possible that Mr. Wrase, even assuming a carotid endarterectomy had been done, could have reformed a plaque or an ulcerative plaque within a year?

A. I agree with ulcerative plaque. I disagree with plaque.

Q. That's impossible?

A. Nothing is impossible. It's improbable.

Q. How do you define "mild stenosis"?

A. I don't use the term "mild stenosis." To me significant stenosis is 50 percent. Less than 50 percent is not

significant. So once it goes over 50 percent, we deal with significance. Most of the time we try to encourage radiologists not to use the word significant, but to give us a number how stinosed it is because sometimes they find that they call it not significant, and it's over 50 percent, and they just miscalculate it.

Q. Or not hemodynamically significant?

MS. ROGERS: Form.

A. Hemodynamic stenosis carries another thing. It's a flow rate. 50 percent is a 70 percent decrease in 50/50 stenosis, but turbulence can also be a significant decrease in flow, so when you're saying "flow," you're talking about a lot of factors.

Q. Well, when we're talking about flow we're talking about what factors?

A. Speed and turbulence.

Q. And when the term "lack of hemodynamic instability" is used, what is meant by that?

MS. ROGERS: Form.

A. Well, it's not used in this term hemodynamic stenosis. It's like a shock patient using hemodynamic stenosis here if

you're dealing with a lamina flow rate, you're looking for a stenosis, an increase in flow rate with a lamina flow. If you're dealing with ulcerative plaque, you're not talking lamina flow, you're talking a flow which would slow the flow rate, but cause like a whirlpool effect, and it could not be lamina, it would be circular around the ulcerative plaque. That's the problem you're dealing with. Also ulcerative plaque, lack of lamina flow.

Q. I'm sorry. Lack of lamina flow?

A. Lamina flow would be a straight flow. In stenosis you narrow the area so the speed of the flow would be going in one direction. A directional op tells you it's going in one direction and speeding up to get through this narrow area. With am ulcerative plaque you get a turbulence; in other words, the flow is actually slowed but not increased, but it's not lamina, it's not going up and down. Let's say it's spinning.

Q. What was the mechanism of turbulence in this case that you believe occurred?

A. Ulcerative plaque.

Q. And in what way did that manifest itself on the carotid ultrasound?

A. Well, you can't see it on the carotid ultrasound, you can't see it, but what it does is, you can hear it and you can measure speed factors, and you hear it by disruption of the flow. Lamina flow has a certain sound. Disruption of that sound is indicative of either increased rate or irregular spinning or irregular flow, like turbulence.

Q. And that's manifested by the high-pitched sound that you heard?

A. Yes.

Q. Is it manifested by anything else on this carotid ultrasound?

A. No, the picture part of this ultrasound is sub optimal. I can't tell you for sure I don't see something, but I can't tell you for sure I do see something on this. I don't read this. This picture I would say is not optimal. Get a better one.

Q. Assuming that there is either a vascular surgeon or a neurologist that is trained and certified in this area that has a different opinion, would you leave room for the

possibility of the validity of that opinion?

MS. ROGERS: Form.

A. Again, I don't know if someone has a different opinion or not, I'm simply saying as far as a vascular surgeon goes, I would assume that a vascular surgeon knows what ulcerative plaque is, knows what it does and has been trained to operate on it, so I believe his opinion would be similar to mine, and his reasoning would be indeed similar to mine.

Q. Assuming that a vascular surgeon in looking at the facts of this case, the carotid ultrasound, the angiogram and any other diagnostic test that was done in this case, came to a different conclusion than you, would it be your position that that opinion would be invalid and contrary to the standard of care?

MS. ROGERS: Form.

A. I would say that I would not agree with that opinion.

Q. But would you make, assuming that there was some valid reasoning behind it, would you entertain the possibility that that opinion could exist side by side with yours?

A. If someone gives the opinion it

exists, I don't agree with that opinion, and I don't think it would be founded on good sound vascular flow rates.

Q. So anybody that disagrees with your opinion, you would think their reasoning would not be founded on good sound medical judgment and principles?

MS. ROGERS: Form.

A. Again, on the basic knowledge of the subject and the flow rates, I would, yes, I would disagree with them.

Q. And the subject of ulcerative plaque in particular?

MS. ROGERS: Form.

A. What we're talking about, we're not dealing with stenosis. There's no stenosis here.

Q. I understand.

A. If he then agreed that there was a stenosis here, I would strongly disagree with him.

Q. We agree that there was not stenosis in this case of sufficient quantity to indicate an operation in and of itself, true?

MS. ROGERS: Form.

A. The answer is I would agree with you that there was no significant stenosis so that, therefore, I would agree with you in principle, yes, stenosis was not the problem in this case.

Q. On the angiogram you already agreed with me that the ulcerative plaque was distal to the bifurcation.

Was it distal to the bifurcation to the left side?

A. We're dealing with the left side.

Q. I just want to make sure.

A. The left side, yes, the right side was --

MS. ROGERS: We can stipulate the issue is the left side, I think.

A. And also one other thing, that the surgeon that operated, I think, agreed with me too.

Q. And you have no criticism of the surgery to the carotid endarterectomy after the second stroke, I take it.

A. No. None whatsoever, none whatsoever.

Q. Can you cite me any literature that

supports angiography of lesions that are not hemodynamically significant?

MS. ROGERS: Form.

A. I don't know what that means.

Q. You used the term "hemodynamic significance" in interpreting or in evaluating carotid ultrasounds.

A. No.

Q. Are you familiar with that term?

A. I'm familiar with the term.

Q. What is your understanding of it?

A. It's a vague term.

Q. So you have no understanding of it?

A. My understanding of hemodynamic is flow. Speed of flow, direction of flow, turbulent flow, again, what directional flow, by directional flow, reversible flow, turbulent flow. All of those fall into that category, they have different significance for different issues. Arteriogram is not done on that arteriogram is purely a road map, you want to get a picture and you want to get the best picture you can. You want to get arteriogram. There is multiple ways of doing it. An MRA gives you an excellent thing, it is a road map

of what's going on. We do that to see more definitively what we're dealing with.

Q. Can we agree you don't do an arteriogram unless you intend to operate?

MS. ROGERS: Form.

A. I would agree with you as to my preference not to do it. However, that is not always standard, and there are places that do MRAs even if operation is not indicated, or there is investigational studies and things like that that are done, and there is no intention of operating. As far as my patients, I would not consider doing an arteriogram.

Q. We're not talking a particular emergency arteriogram now, not MRA?

A. Right.

Q. Unless one intended to operate, correct?

MS. ROGERS: Form.

A. True. But you've discounted MRA. I might do an MRA and not do an arteriogram.

Q. Under what circumstances would you do an MRA?

A. We do MRAs pretty at a drop of a hat now. They're safe, and if the center that

we have has a good track record, we do MRAs and with no intention -- not no intention, but little intention of operating, just to be definitively sure.

Q. Getting back to this term, no evidence of hemodynamic stenosis. I think there is -- this report of the carotid ultrasound said there was no hemodynamic instability. Is that what he used?

A. I have to pull it out.

Q. I'm sorry. He said "No evidence of hemodynamically significant stenosis."

A. Okay.

Q. Do you ever use that term?

A. Yes.

Q. What is your understanding of that term?

A. That basically means that the flow rate is not indicative of significant narrowing of the vessel.

Q. Do you agree with that interpretation?

A. Yes.

Q. You take issue, though, with the high-pitched sound and turbulence?

A. We're talking two different issues. The issue he's dealing with is flow rates mainly. His flow rates that he has there is not indicative of a significant increase in flow rate, which would indicate an increase in stenosis. The high-pitched sound is indicative of disruption of flow, et cetera, not specific in the fact that I can't tell you is it an ulcerative plaque the size of the ulcerative plaque, or is there something in the stenosis that is causing this high-pitched sound. Okay. But if your flow rate is normal, then all of a sudden you say, "Well, it's not due to a narrowing, it has to be due to something else."

What else could it be done to, and the next thing that comes up is ulcerative plaque. So I agree there is no stenosis. There is no sign hemodynamically of stenosis, but there is sign hemodynamically of plaque.

Q. Are you familiar with the term cryptogenic stroke?

A. Cryptogenic means there's a stroke. Nobody knows.

Q. Of idiopathic origin, correct?

A. Yes.

Q. Can we agree that with or without treatment the risk of recurrent stroke in a patient who is symptomatic is approximately five to eight percent?

MS. ROGERS: Form.

A. Five to eight percent?

Q. In the first year after stroke.

A. Without any cause.

MS. ROGERS: Form.

Q. Any type of stroke?

A. No. Without any cause. In other words, if there is no cause found, there is no reason to stroke. In other words, you can't find a reason, there's no stenosis, there's no ulcerative plaque, there's no narrowing of the arch, no heart problem, no nothing, no this, no that, I agree.

Q. Okay. What is the rate of recurrent stroke for ulcerative plaque without treatment?

MS. ROGERS: Form.

A. 25 to 50 percent in the first year. It goes up higher each year you don't treat it.

Q. What is the rate of recurrent stroke that is treated with carotid endarterectomy?

A. Are you talking about immediately post op?

Q. Let's take within a month, within six weeks, eight weeks.

A. Usually what they talk about is postoperative stroke of two to five percent. That's usually within the peri operative period, and different studies define peri operative in different terms. One can be a week, one can be two weeks, one can be a month, but peri operative stroke is about two to five percent.

So I've seen studies that go to a month. So if you want to include that, that would be basically my answer. Same thing first 24, 48 hours, it's about the same.

Q. Do you -- after an initial stroke, is there any amount of waiting time that one would use in the performance of a carotid endarterectomy, assuming one was considering it and it was indicated?

A. If you're talking about a TIA with

no CAT scan area of hemorrhage, the answer is rapidly.

Q. What do you mean by "rapidly"?

A. As soon as possible.

Q. Okay.

A. Which would mean in that hospitalization you would try to do it to decrease the possibility of re stroke. If they had a significant hemorrhagic area and they reversed in the first month, then you would schedule them again as soon as possible after they recover.

Q. Would you want to wait to see if there was some resolution of symptoms?

A. You look for resolution, but not in -- you would look for resolution not to 100 percent. You would look for the process of resolution. The patient is getting better, his weakness has gone down, he's improving again dramatically, his functions are coming back, that's why you don't want him to re stroke. If he remains with hemiparesis, what's the use of re operating, you already lost. You want him to return to function.

Q. Would you wait until he returned to

function for the most part before you would operate or consider operating?

A. You would again wait for him. You would want the process to be improving, and that would be rapid improvement. Not over six months, but in the first month improves, yes.

Q. Can we agree you would want to wait approximately four to six weeks to see if there was some resolution or improvement?

MS. ROGERS: Form.

A. Not necessarily. If there was improvement within the first week, and the CAT scan showed no hemorrhagic area, I would be inclined to operate on this guy pretty rapidly.

Q. "Rapidly" being?

A. A week, two weeks, ten days. I would try to do it as quickly as physically possible being done, barring any medical problems.

Q. Would you want to wait until the motor deficits had resolved?

A. Not resolved. Improved, significantly improved.

Q. Improved. Are you aware of any studies that take the position that with

minimal stenosis or stenosis of less than 50 percent that there can be, the risk of endarterectomy can outweigh the benefit of it?

MS. ROGERS: Form.

A. In minimal stenosis within stenosis, without symptoms, without stroke or TIA, the answer is yes, you risk two to five percent of having a stroke with the operation and why it outweighs it is because the patient does not have a significant stenosis; therefore, his chances of stroke is probably that or a little bit less, so you wouldn't do it.

Q. What about symptomatic patients?

A. That's a different story.

Q. I know, that's why I'm asking the question.

A. Again, with minimal stenosis, and you can -- basically that's the cause of it, and usually that's a hard thing to find, but if that's the cause of it, then you might consider doing it in the face of less than 50 percent.

Q. But there are studies that say that with symptomatic patients with minimal stenosis of less than 50 percent, the risks of

endarterectomy outweigh the benefits, and there is no clear indication of an endarterectomy.

MS. ROGERS: Form.

A. You have to cite the articles, because the articles say if a patient had a stroke and is symptomatic and it's attributable to that, that's a patient you would consider doing an endarterectomy.

Q. How about the NACET study symptom plaque patients with less than 50 percent stenosis, there's no appreciable benefit for endarterectomy, and the benefits would not outweigh the risks?

MS. ROGERS: Form.

A. With previous stroke?

Q. With previous stroke.

A. That terminology I'm not familiar with, but as I said, I have not done a literature search, and in order to joust with you, I would be more than happy to do one.

Q. Are there certain things to indicate endarterectomy, sir?

A. Of course.

Q. What are they?

A. Bleeding. Bleeding, and of course

ultimately infection, there's stroke, there's emboli, there's damage to peripheral areas. Again, these are normally sick people. They carry a risk of operation in general. Arterial is usually not confined to their heart, there are other complications that can occur, but the main complication can be bleeding and stroke.

Q. You can have recurrent stroke with a carotid endarterectomy?

A. Again postoperative peri operative stroke you can have a peri operative stroke, that's true.

Q. The peri operative stroke is what?

A. Again it's ill-defined by a lot of people. Usually they stay within the first couple days, first week. I've seen it within a month, they call it peri operative.

Q. What do you usually call it?

A. Peri operative, usually within a week.

Q. Are you familiar with any study that says that the benefit of endarterectomy outweighs the risk in symptomatic patients with less than 50 percent stenosis?

MS. ROGERS: Form.

A. Again I haven't gone through the literature, so I can't make comments if a study like that exists. I haven't done any research, so I can't cite one.

(A discussion takes place off the record.)

Q. What was the degree of ulceration in this case?

A. I don't think they gave a degree. Let me take a look. They only mentioned ulcerative plaque.

MS. ROGERS: Can I show him?

MR. BERMAN: Sure.

MS. ROGERS: If this helps you.

THE WITNESS: I have it. Thank you?

A. It only says that the operative report, an endarterectomy of a calcified arterial plaque, ulcerative plaque with large calcification in the containing blood clots and platelet aggregation was carried out.

Q. What does the pathology report say about ulceration, if any?

A. Do you have this available?

MS. ROGERS: I've got it right

here.

Q. Does the pathology report indicate any presence of ulceration?

MS. ROGERS: Form.

A. Other than saying irregular fragments of yellow tissue measuring two by one by a half, it doesn't mention specifically ulceration, but it does say irregular fragments. So it doesn't appear to be one piece. So I don't think you can possibly say you can tell exactly what.

Q. What does irregular fragments mean, irregular in size and shape that the pathologist was looking for?

MS. ROGERS: Form.

A. Pathologist means pieces. I don't know if this was taken out in pieces. He was just describing the fragments he got that were irregular, and also ulcerative plaque is definitely irregular. It's an indentation that's irregular.

Q. But there's no indication in the pathology report that there's a indentation or --

A. No, true. This was taken out of

one piece, so I don't think that's really fair.

(A discussion takes place off the record.)

Q. Assume, Doctor, I want you to assume that there was a carotid endarterectomy after the first stroke. What would be the risk of morbidity or mortality from the first stroke alone?

MS. ROGERS: Form.

A. The morbidity of the stroke, two to five percent. For this patient mortality would be very low.

Q. And are you including in that the risk of recurrent stroke?

A. Yes.

Q. I just want to make sure I understood you.

A. Yes.

Q. Was Mr. Wrase hypertensive?

A. Yes.

Q. Did he have hyperlipedema as well?

A. Yes. And hyper cholesterol.

Q. Does that increase his risk of recurrent stroke?

A. That increases the risk of arterial

sclerosis, not a stroke or not plaque in the same place. You have a higher disposition with these factors to develop plaque all over your body with these.

Q. Do you have a higher redisposition to redevelop plaque with these conditions?

A. Not necessarily develop, but you have a higher definition of plaque formation with arterial sclerosis.

Q. With these factors you have a higher likelihood of having atherosclerotic disease?

A. Absolutely.

Q. Doctor, can we agree that angiography can be insensitive to detecting angiography for plaque?

A. No.

MS. ROGERS: I didn't hear the answer.

A. No, I don't agree with that. If it's done properly with multiple views, like it should, if there's plaque there and ulceration, you should see it.

Q. Are you aware of the fact that ulcerations were excluded from the NACET study?

A. Again, I don't have the NACET study in front of me, and I didn't do it. I don't have intimate knowledge of it in front of me, so I can't tell you.

Q. Don't you think you should have intimate knowledge of it since it's directly related to the --

MS. ROGERS: Form. Since it's related to the form.

A. No. You're telling me a study most of which are different than this, most of which have some evidence.

Q. Do you practice evidence-based medicine, sir?

A. I don't know what that means.

Q. You don't know what?

A. Medicine is not legal. Medicine is an art.

Q. How about evidence-based in terms of statistical data to support what treatment modalities are effective as opposed to anecdotal evidence?

MS. ROGERS: Form.

A. Again I can't even answer that question because what you call anecdotal seems

factually correct, there are many studies out there that are based on many falsehoods, and you can treat patients wrong by listening to a study which may not have any bearing on that or even be factual.

Q. Do you use any literature in connection with the way you treat patients?

MS. ROGERS: Form.

A. The answer is yes.

Q. And how do you use that?

A. Simple. I've trained, I have knowledge of the field. If I need to do some update of something unusual, I will do an update, and I will read accurate things and current treatments, and we have changed.

Q. What do you look at to keep current or to find out what are the new thoughts in the practice of medicine as you practice?

A. The British Journal of Surgery I use; American Journal of Surgery I'll use. I'll go through other journals, laser journals, laparoscopic journals I go through. Those are the ones I see when I go to the library I look at.

Q. What are the journals you refer to

in terms of what's going on with the decision to use carotid endarterectomy versus not use corticosteroids?

A. Well, the vascular journals that are out there, I look at those, and also articles in other journals about vascular surgery. There are a number of articles out there, not all of them, as I said, are definitive articles. Some are mainly opinions, some are descriptive techniques, some are -- some of them pertinent findings, which we may not agree with.

Q. But you look at them to keep an open mind and see what is going on in your field, don't you?

A. I read them with a very, very skeptic eye, and I don't believe every -- no, I don't believe every article that is written. I believe many articles are written for the purpose of writing an article, and they may not be based on significant factual basis.

Q. You would agree you would have to look at each article in particular to make that determination, true?

A. In general you would have to look

at the article to determine whether you believe they have some credibility or not, but again, you take every article with a jaundiced eye because we know generally what's worked for a number of many years, and when someone comes along with some new ideas which may not work or they may work, you want to be very conservative in changing.

Q. Why were there studies in regard to the risks of carotid endarterectomy versus the benefit? Why did they have those studies, sir?

A. They've been having those studies for many years. And many of the articles were written with the expressed intent to try and get away from surgery because surgery is relatively more expensive, and so a lot of the drug companies write articles showing that their drugs were very, very efficient. Even the aspirin companies ran studies, because if they use their drug, they make a ton of money.

So when those studies are financed by people who have a vested interest in people who push medication, I take that with a great deal of skepticism. Many doctors on these are being paid by them to run these studies.

Q. Do you have any opinion whether the NACET study was funded by the drug companies and has the bias?

A. I know a lot of people don't agree with a lot of portions of it. The answer is I don't know if it has a bias or not. I mean, I'm sure we can find out.

MS. ROGERS: Ken, are you going to have any questions?

MR. MORGAN: I don't know. Am I going to have any questions.

MS. ROGERS: No. We can stipulate, if I haven't already done so.

MR. MORGAN: You have. I think we can just say it in the end. I think that's the end of the day.

MS. ROGERS: I'm not going to have any questions, but we need to give Bob a chance to go over his notes, and certainly he's entitled to ask.

MR. MORGAN: He is.

MS. ROGERS: The court reporter needs a break.

MR. BERMAN: That's fine.

(Brief recess.)

Q. Doctor, was Mr. Wrase a diabetic?

A. I believe he was. I would have to check that.

MS. ROGERS: Do you want him to check?

MR. BERMAN: Yeah, I don't mind. I think he was, but I just want to make sure.

Q. Generally, I don't see diabetic. I thought somewhere I might have it.

A. I thought there might be some.

MS. ROGERS: I thought so too.

A. I don't see that he's on any medications.

MS. ROGERS: No Glucophage or insulin?

THE WITNESS: I don't see it.

Q. Okay. Doctor, have you now told me all of the opinions that you have relative to standard of care and causation with regard to Mr. Wrase?

A. I have.

Q. Have you been asked to create any demonstrative aids?

A. Not at this point, no.

Q. As I understand it, you talked

about the quality of the carotid ultrasound, you've talked about whether or not there was a reordering of the carotid ultrasound or an angiography and/or MRA. Now, I assume that you're also saying, you may have said it, that a vascular surgery consult was indicated as well.

A. If they found the ulcerative plaque, I would have called a vascular surgeon in, which they did at the end, and my assumption would be that he did the same thing he did in the end, only earlier.

Q. What do you base that assumption on?

A. My training, knowledge and experience.

Q. Anything in the records that you base it on more than your training, knowledge and experience?

A. Also, when they saw an ulcerative plaque they called in a vascular surgeon.

Q. The guy was there for two strokes, wasn't he?

A. I don't think he was there for the two strokes. I think he was there because it

was generated by the fact they found something the surgeon could do. It's not the same as one stroke.

Q. Are you critical of him waiting approximately six or eight weeks to operate?

A. Not after the second stroke, no.

Q. Okay. Is there any study that you're aware of that talks about recurrence of stroke with carotid endarterectomy?

A. I haven't done a literature search, but I'm sure he was cognizant of the fact the man had two strokes, and that we're in another realm. He needed surgery and more caution. He already had two strokes, and you want to make sure he's improving, number one, and you also have to make sure there's no hemorrhagic areas for vascularization.

Q. And he was now in a different subset of patients because he had had two strokes, correct?

MS. ROGERS: Form.

A. Correct, right. And he was also one of the few that makes it through two strokes without significant loss. And without significant loss the question of surgery

becomes more difficult.

Q. Because of the risk of re profusion injury?

MS. ROGERS: Form.

A. The fact that after the second one you have a higher incidence of re stroke. You have two strokes already, there's decreased intra cerebral flow and vascular trauma. After two injuries the re profusion of the vessels, they don't respond very well. We're in totally different areas at this point. The fact is I don't object to his waiting. The fact is I would agree with him, what he did was perfectly fine. The wait was not inordinate, and the re operation in this man's condition would have been appropriate.

Q. Have you reviewed the records of Naples Community Hospital or Collier Hospital?

A. I don't believe I have.

Q. Are you aware that he had a seizure, I believe, in November of 2000?

A. I don't think I have those records. It doesn't sound familiar.

Q. Assuming that he had a subsequent seizure, say, in November of 2000, what would

be the potential causes of that?

A. Seizures.

MS. ROGERS: Form.

A. A lot of reasons not necessarily related to this stroke. Seizure is when there is a stroke right where is his findings right side, left side, there can be other factors. I can't answer.

Q. So you have no opinion?

A. I have no opinion, and I have no information.

Q. Have you asked for any materials that haven't been provided to you?

A. Not at this point.

Q. Do you intend to do anything else with regard to this case?

A. Nothing unless I'm asked.

Q. Okay. Assuming that you're asked, and you develop additional opinions, I assume Mr. Freidin's office will advise us, and we will have the opportunity to redepose you, correct?

MS. ROGERS: I think that's a fair assumption on your part, Mr. Berman.

MR. BERMAN: Thank you.

MS. ROGERS: But it appears he has stated his opinions at this time, and that they're final at this time.

MR. BERMAN: Okay.

MS. ROGERS: And I don't anticipate us giving him anything else unless someone wants to come up with a demonstrative exhibit, but we'll let you know if something changes.

MR. BERMAN: That's fine. That's all I have. Thank you.

MS. ROGERS: Mr. Morgan.

EXAMINATION BY MR. MORGAN:

MR. MORGAN: Doc, I'm Ken Morgan. I represent Holy Cross in this case, and, Susan, quite frankly, if you want, you can stipulate with me.

Doctor, it's my understanding that you have no opinions with respect to the standard of care or whether there were any departures from the standard of care of any of the agents, servants or employees of Holy Care Hospital in the --

A. I would agree with that as long as the doctor wasn't employed by the hospital, and it's my understanding he wasn't.

Q. Fair enough. And as I understand it, your opinions are limited to Dr. Cimera in this case; is that accurate?

A. That's correct.

MR. MORGAN: Is that correct, Susan?

MS. ROGERS: Yes, it is.

MR. MORGAN: Fair enough. In that case, I have no questions.

MS. ROGERS: Do you have anything else, Rob?

MR. BERMAN: Just one thing, I just want to think.

MS. ROGERS: Read or waive?

THE WITNESS: Read.

MR. BERMAN: I would like the correspondence attached as Defendant's Exhibit 1. I would also like the billing records --

MS. ROGERS: Sure.

MR. BERMAN: -- as Defendant's Exhibit 2. I don't need the other stuff.

Oh, did you make any notes?

THE WITNESS: No.

MS. ROGERS: He said no.

MR. BERMAN: Did you highlight any

portions of the depositions?

THE WITNESS: No.

MS. ROGERS: He just read summaries, I think. Thank you, Dr. Becker.

THE WITNESS: You're welcome.

(Whereupon, the above-referred to correspondence was received and marked Exhibit Defendant's 1 for identification.)

(Whereupon, the above-referred to billing records was received and marked Exhibit Defendant's 2 for identification.)

(Deposition concluded at 4:45 p.m.)

C E R T I F I C A T E

I, MARIA L. GIGLIUTO, a Notary Public and Certified Shorthand Reporter of the State of New Jersey, do hereby certify that prior to the commencement of the examination, DR. STEVEN IRA BECKER was duly sworn to testify to the truth, the whole truth and nothing but the truth.

I DO FURTHER CERTIFY that the foregoing is a true and accurate transcript of the testimony as taken stenographically by and before me at the time, place and on the date hereinbefore set forth, to the best of my ability.

I DO FURTHER CERTIFY that I am neither a relative nor employee nor attorney nor counsel of any of the parties to this action, and that I am neither a relative nor employee of such attorney or counsel, and that I am not financially interested in the action.

_____

MARIA L. GIGLIUTO, CSR
Notary Public of the
State of New Jersey
License No. XI02086

Commission Expires April 6, 2004