MEMORANDUM

TO: Hans

C: File

FROM: Bob

DATE: October 30, 2013

SUBJECT: **DISCOVERY DEPOSITION OF DR. SCOTT SAGERMAN**

CASE: PAUL DULBERG

On October 15, 2013, I attended the discovery deposition of Dr. Scott Sagerman regarding his treatment of our client, Paul Dulberg. To review, Paul was injured in a chainsaw accident in which his right forearm was significantly injured and damaged after a chainsaw struck it while helping a friend cut down a tree limb.

FAVORABLE TESTIMONY:

In summary, the doctor was able to tie the forearm pain and symptoms being muscle pain and weakness in gripping and pulling things in his forearm to the accident. It was a deep laceration to his forearm and there was some injury to those muscles and nerves which may have been causing the pain in that area. The surgery to the forearm and treatment of that he felt he could easily relate to the accident.

UNFAVORABLE TESTIMONY:

In contrast to the positive points, the cubital tunnel injuries and subsequent surgeries and treatment that Paul had in his right elbow would be difficult to relate back to the accident and the doctor basically said that it was too far distal from where the chainsaw struck him to have been caused by the accident. Furthermore, any subsequent pain Paul would have had to his left arm would also be a stretch to show that that was somehow related to overcompensate him from the right arm. The doctor did note that it was possible, but I don't know that we can firmly count on his testimony to show that to be a viable claim.

SUMMARY:

On October 15, 2013, I attended the discovery deposition of Dr. Scott Sagerman in Paul Dulberg's case. The doctor identified himself as an orthopedic surgeon with specialties in hand and upper extremities. He did have some recollection of Paul from the numerous treatments of him. This accident occurred on 04/28/11 and the first visit with Dr. Sagerman was on 02/27/12. He does know that he had seen Dr. Sek prior to this as well as Dr. Levin and Dr. Talerico.

The doctor did note that he had seen Paul sometime in the past in 2003 and 2004 when he was diagnosed with cubital tunnel syndrome in his left arm. This is an ulnar nerve condition regarding

compression of the nerve in the elbow. The ulnar nerve is the main nerve behind the elbow in the cubital tunnel area. It extends to the inner side of the hand and provides muscle function to the hand. The symptoms of this syndrome would be numbness and tingling on the inside of the hand, mainly the ring finger and the small finger especially. This is significant as it also notes the same symptoms that Paul had displayed, along with others, in his current treatment with Dr. Sagerman. It is further significant because Dr. Sagerman was not able to tie that cubital tunnel syndrome and symptoms to the chainsaw accident. This earlier treatment in 2003 and 2004 showed the same symptoms and the same type of ailment as he was currently claiming of with his right hand now. The onset of this prior treatment was a motor vehicle accident in March, 2002. The doctor did not have anything else specific regarding that. He noted that the common causes of cubital tunnel syndrome is a compression on the nerve. It may be spontaneous or as a result of injury to the vicinity or it can also be from strenuous activities. As to whether it can be caused simply by repetitive use, he doesn't think so. He noted that these quite type of activities generally cannot create such an ailment. Back then, surgery was done to correct the cubital tunnel and it was successful.

Bring us up to more modern times, in February, 2012, he first came to him for the injury resulting from the chainsaw accident. He didn't really know how it occurred but he does have some history in his medical records. In February, 2009, he did send a letter to Dr. Sek regarding his treatment with Paul which he had on his first visit on February 27, 2012. He noted in that letter that Paul developed symptoms of numbness in the small finger as well as weakness and that he treated it with therapy and had an EMG test and an MRI scan. He noted that he did not have the emergency room notes at that time. Regarding the past medical history, it does note some arthritis as well as cervical disc disease. The doctor did not know much about this but it looked like it was in the neck area. There were various medications that he was on at the time as well and noted that they were for anti-inflammatory, a pain medicine, depression, and for muscle spasms. Regarding his exam on that first appointment of February 27, 2012, the doctor basically read from his notes on that day. He noted there was a large scar on the mid forearm between the elbow and the inner side in the wrist. He noted positive Tinel sign which is conducted by tapping over the nerve area and it will show pain or indicated nerve dysfunction or injury. This is a subjective finding. On the cubital tunnel region on the right side, there was sensitivity there also. Wrist and elbow motion were unrestricted and there were no visible signs of atrophy. He noted that he was able to abduct the small finger which is to pull it sideways from the other fingers. His flexion strength was normal. X-rays showed no fracture. He reviewed the films of the MRI from February 3, 2012 and noticed no abnormalities. The MRI report noted weakness in the ring and small finger. He noted that even though there was nothing abnormal in the images that he was not too exclude the possibility that the nerve was still injured. He noted that just because it's not in the film that there may still be some nerve injuries in and around the point where Paul was complaining. The nerve conduction study was also conducted on August 10, 2011, and there was no evidence of neuropathy. This is a negative finding, however, it does not rule out the possibility of the nerve injury. Same as the MRI report. That being said, it is important to note that simply because these two studies, being the MRI and nerve conduction study, did not show anything abnormal, that does not mean that there is not a nerve injury still present. His impression was that the right forearm was a laceration with probable partial ulnar nerve injury. At the scar area, he noted there was a deep laceration there and there may be ulnar nerve issues. It is possible that the nerve could have been directly damaged. He was showing signs of an ulnar nerve injury and local sensitivity in that area of his forearm. That is further suggestions of such a nerve injury. He then sent him for a follow up for an EMG. This is different from a nerve conduction study in that the nerve conduction study studies and evaluates the velocity of the nerve impulses. An EMG tests the muscle to be indicative of an injury. He wanted the EMG because it

will give a more complete analysis. He felt in his opinion that was warranted. They also brought up surgery at that point as a nerve exploration to expose the area of injury. The EMG was ordered and no work restrictions were put into place. The EMG was done with Dr. Levin on March 13. The next visit with Dr. Sagerman was on 04/02/12.

On 04/02/12, Dr. Sagerman had another appointment with Paul Dulberg in his office. He had the EMG tests which was done by Dr. Levin and it showed no evidence of neuropathy. It also showed that the nerve conduction was within normal limits. At that point, there was no documentation that the nerve was not functioning properly. There was still a positive Tinel sign which is subjective and there is still the abduction of the small finger with a positive Wartenbergs sign. It is noted that he did not wish to pursue surgery at this time but there were some recommendations given for strength exercises and scar management.

The next visit was on 05/14/12 and there were new complaints at this point. Paul was having issues with persistent pain with the use of his arm as well as gripping and squeezing things. There was no change in the symptoms of numbness or tingling in his fingers, but that was not bothersome to him. His function in the arm was limited due to pain symptoms. Upon examination, he found that the Wartenberg sign is still positive and his intrinsic strain is slightly weak. This weakness was of the muscles in the hand that control the fingers. There was also no clawing. This would be an abnormal posturing to the finger due to the muscle issues. This is commonly seen in ulnar nerve injuries. However, there were no signs of clawing in Paul on that date. The discussion was had regarding possible surgery for an ulnar nerve neurolysis. This was more of an exploratory issue to find out what was bothering the nerve and to decompress the nerve. His next visit, he was ordered to follow up with a different doctor, being Dr. Sam Biafora. This was to get a second opinion on his pains and it was suggested by Dr. Sagerman to do this.

The next visit was on 05/17/12 with Dr. Sam Biafora. Dr. Sagerman testified as to what Dr. Biafora had noted in his records which we have. He noted in his records that he was to see Paul for a second opinion after being referred to him by Dr. Sagerman. He noted that Paul sustained a chainsaw injury to his right forearm. He noted that Paul told him that he had a partial nerve injury in the emergency room. On this day he noted weakness in his right hand as well as numbness in his right small and ring fingers at rest with occasional tingling. He also reported a shooting, burning type of pain which radiates proximally and distally from the area of the injury in the proximal forearm. He noted this occurs several times a day at rest and more predictably with use. Upon physical exam, Dr. Biafora noted that there is a positive Tinel at the cubital tunnel through to approximately several centimeters distal to that. There was also transverse swelling and a heeled scar several millimeters in length at the proximal third of the forearm on the ulnar side. He also noted that there is a positive Tinel over the scar and at the most volar radial aspect of the scar. There is also significant tenderness at the scar to deep palpation on its most ulnar and distal border near the ulna. He also noted Tinel over the most volar and radial aspect of the scar radiates into the ulnar digits. He noted there was still positive Wartenbergs signs. He did have good strength and flexation of the small and ring fingers but there is pain at the scar on its most dorsal and ulnar border with resisted DIP flexion of the small finger. His assessment was that he felt there was approximately a 1 year status post the laceration and there was likely a partial ulnar nerve injury with ulnar nerve neuritis. Dr. Sagerman explained this to be that at the site of injury, there was a potential at that location for dysfunction of the ulnar nerve. That would explain some of the symptoms Paul has had and he has been experiencing in the ulnar nerve in his hand as well. Dr. Biafora also recommended surgery and felt that the patient "may benefit from an ulnar nerve exploration with neuroysis". He also noted that he would recommend this also

to include the cubital tunnel decompression with possible anterior transposition. He noted that it will not likely improve the motor deficits in his hand but it may improve the pain that Paul is experiencing in his forearm. He noted that he also had separate and distinct tenderness in the most dorsal ulnar aspect of the wound and it may require exploration of that portion of the scar as well. Paul noted that he wanted some time to think about it before he made a decision and will follow up with Dr. Sagerman in four weeks.

The next visit was with Dr. Sagerman on 06/06/12. He noted that prior Dr. Levin had given him Neurontin to treat the nerve pain that he was having. Dr. Sagerman normally doesn't give that drug and he feels there is problems with side effects and there is a better prescription for him to have. On that date he reported no change in his symptoms despite that medication. However, he is noting some side effects from that medication which may interfere with his functioning. Paul at that time noted he would like to proceed with the surgery that was discussed with Dr. Biafora previously. He also had had additional therapy but it was discontinued due to lack of progress. He went on with the physical examination and noted that the right elbow and forearm was unchanged. There was a positive Tinel sign present at the cubital tunnel without ulnar nerve subluxation. The forearm scar is stable with tenderness and sensitivity to percussion. He indicates he had pain when he was trying to grip things which was localized to the forearm region and resulted in increased numbness in his ring and small fingers as well as weakness in his grip. The surgery was discussed and Paul noted that he feels that any improvement in the symptoms will be beneficial in terms of his arm functioning normal. There was a bit of a discrepancy here between this visit and the last one in which on 05/14 it was noted that physical therapy seems to be getting him some benefit but as of the 06/06 appointment, it is noted that physical therapy is not helpful. The doctor could not explain the difference between the 2 or why that was the case.

Paul then had his surgery on 07/09/12. The doctor noted at that time that prior to the surgery regarding Paul's prognosis, the doctor was very guarded in his prognosis. He didn't really know how much improvement there was going to be as it is hard to predict how much better it is when you don't know the extent of the nerve injury, which is all the more reason why you are going in for the exploration to determine the extent of the surgery.

The surgery was on July 9th. The pre-operative diagnosis was the same and this was an outpatient type surgery. There were 2 things that they were going after in the surgery. No. 1 was the right elbow cubital tunnel issue and release and there was also the pain in the right forearm. Regarding the cubital tunnel release which is done in the right elbow, it did show thickening of the cubital tunnel ligament with scarring of the ulnar nerve to the floor of the cubital tunnel with local constriction. This basically meant a pinched nerve in the elbow area. This was in essence the same type of procedure or injury Paul had suffered back in 2003 and 2004. However, the doctor could not 100% confirm that as he did not have those records. What he found would be consistent with cubital tunnel syndrome and its causes. He did note regarding the surgery to the right forearm that there was a very deep laceration into the muscle which covered the nerves but the muscle fibers were actually in tact. He noted in his report that the site of the previous chainsaw laceration revealed extension to the subcutaneous tissue and fascia overlying the flexor carpi ulnaris muscle. He noted that the nerve was not cut and there was no visible scarring around the ulnar nerve at that level. The findings in this were important for us in that it showed that these were consistent with his complaints. It seemed that from the laceration, what he found would account for Paul's symptoms. He basically went on to discuss the scarring of the muscle and whereas it is maybe difficult to say, he felt the scarring of the muscle may have caused the ailments that Paul was suffering from. He also noted

that as far as the cubital tunnel, that would account for the ailments that Paul was suffering in his ring and pinky finger. These are two separate independent findings at two different sites. In summary as I will go over later, it basically noted that the doctor would tie the injury to the forearm and that weakness and lack of grip to our accident. However, he would not tie the cubital release in his elbow to the accident as he felt it was too distal from where the accident actually occurred.

The next visit was on 07/11/12. There did not seem to be any real issues at that time and the patient was doing well. His function had increased and his symptoms had improved and his strength had increased. He still had some soreness in his elbow and that was normal. As far as restrictions at work, he did not feel that Paul should have any as doing work sitting at a computer.

The next visit was on 07/23/12. At that time, Paul seemed to be doing fine.

He then saw him on 07/30/12 and noted also that he was doing well and his arm feels much better and he has increased function and feels that his symptoms have improved.

The next visit was on 08/27/12. On this, he noted that Paul was doing okay and that his elbow was sore and he was participating in therapy. His progress at this time was satisfactory and his grip strength had increased and his hand function had improved. There were no signs of infection or any other issues. He was told to continue his therapy and come back in about 6 weeks.

His next visit was on 10/22/12 and he noted he was feeling better. His function has improved and he is gaining strength. The sensation in his fingers has improved and he is pleased he can now grasp objects better then he did before the surgery. He still has some difficulty with certain activities regarding gripping and pinching of small objects. He was examined and it was noted that he will continue his home exercises as well as those given by his therapist. He can also advance in his activities is as tolerated. He noted on this time that they discussed work activities and that Paul noted he is currently unemployed and plans to pursue disability. They noted the next visit in 6 weeks.

The next visit was on 12/03/12. On this date, he was in for an evaluation of his right hand and right arm. He noted he still has some weakness and pinch strength and difficulty grasping objects. But he is performing his home exercises. It is at this point that he also notices an onset of left elbow symptoms with no proceeding trauma. After an examination, the doctor's impression was that he had a left lateral epicondylitis. This is a degeneration of the elbow which basically is tennis elbow. Causes are normal wear and tear and are degenerative. The fibers lose their strength and it causes issues. This can be caused by blunt trauma or certain actions can cause it also. As to whether it will be caused by over compensation, that would seem to be a stretch, according to Dr. Sagerman. Most of it was the same and this examination was predominantly on the left arm and again, as stated before, he did not really feel that these injuries would be caused by over compensating from the injury he had to his right arm.

The next visit was on 03/25/13 and all is really noted regarding the right arm on this visit is he did have some intermittent soreness in the right forearm area. Nevertheless, the scar was stable and there was mild sensitivity at the most ulnar aspect of it. At the right forearm scar, a padded elbow sleeve was provided for protection and he may follow up on an as needed basis if symptoms worsen. On that date, it looks like he gave a steroid injection, but was not asked significantly about this during the deposition. Again, this seems to be an unrelated ailment.

The next visit was on 08/26/13. On that visit, he did come in for some slight intermittent pains in his right forearm in the muscle cramping area. He noted that the right forearm scar was stable with no focal tenderness to sensitivity. But he did describe intermittent muscle spasms with discomfort despite the medication. Dr. Kathleen Kajawa suspects possible dystonia. He was then referred out to a neurologist.

Regarding the doctor's opinions of his injuries in relation to the chainsaw accident, he noted that the chainsaw injury was a deep laceration of the right forearm. He felt that the injury to the forearm from the chainsaw was definitely related to our accident. He felt also that the surgery to that forearm was also related to the accident and the pain and symptoms that he was feeling in his right forearm would all be relatable to the chainsaw accident. As for the prognosis of that, he felt Paul should remain stable within a certain degree of certainty, the symptoms should remain unchanged as to what he would expect.

Regarding the cubital tunnel syndrome, he did not feel that that was related to the accident. He felt that the injury to the elbow where the cubital tunnel is located as well as the surgical procedure that they did there was too far from the forearm to relate it to the accident. As to whether the injury to the forearm could be some kind of a by-product of the cubital tunnel, he really didn't think so. He felt that the injury from the chainsaw was too distal to the elbow to effect the elbow in the way that they found. The injury would account for the scarring as well as the lack of grip and weakness that he was having in his forearm. However, the cubital tunnel would account more for the numbness and tingling in his fingers and that he could not attribute the accident.

Regarding any disability, as for the forearm, he would have difficult time pushing, pulling or lifting certain things at times. He would have to accommodate for that impairment in doing those activities. He could do some of those things to the extent that his forearm and the strength would allow him to do that. As to whether he can work at all from the forearm injury, he can work as it is tolerated. The doctor did note as to whether that makes him totally disabled would probably not be the case. Especially with the fact that he works at a computer most of the time. As to whether there is any overlap between the injury to the forearm which is relatable and the cubital tunnel which does not seem to be relatable, the doctor did note that you really have to look at the medical records to evaluate which of the charges could be deemed relatable versus not. They are two distinct and separate surgeries and incidents, but nevertheless, there are probably is some overlap between the two of them and there is treatment for both areas on any number of the doctor visits. As to whether the left elbow pain could anyway be related, the doctor felt it would be quite a stretch to do that but it really would depend on what you are doing with your left elbow. He would not commit. After surgery, as to whether he had full disability, it really depended on his function and his abilities to do whatever it is he was being asked to do. Again, as to whether it is a total disability, the doctor felt it was hard to say. But if it was a computer based job and he would not have to do any strenuous work, such as pulling, pushing, lifting, or whatnot, and if he stuck mostly to the computer-based jobs, he doesn't know if he could say he would be totally disabled.