

IN THE COURT OF COMMON PLEAS
GEAUGA COUNTY, OHIO

PATRICIA M. FLETCHER,
Ammin., etc.,
Plaintiffs,

vs.

Case No.

GEAUGA HOSPITAL
ASSOCIATION, INC.,
et al.,
Defendants.

97PT000126

- - - - -
Deposition of LOUIS ADLER, M.D.,
taken by the Defendants, at 3:13 p.m.,
on Friday, the 5th day of May, 2000, at
9876 Wilshire Boulevard, Beverly Hills,
California, before Marie Striegler, CSR
No. 6032 in and for the State of
California.

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1 APPEARANCES:

2 On behalf of the Plaintiffs:

3 FINELLI & MARGOLIS, P.L.L., by

4 RONALD A. MARGOLIS, ESQ.

5 730 Leader Building

6 526 Superior Avenue

7 Cleveland, Ohio 44114

8
9 On behalf of the Defendant

10 Dr. Blackburn:

11 MAZANEC, RASKIN & RYDER CO.,

12 L.P.A., by

13 D. CHERYL ATWELL, ESQ.

14 100 Franklin's Row

15 34305 Solon Road

16 Cleveland, Ohio 44139

17
18 On behalf of the Defendant

19 Dr. Darwin:

20 FALLON, PAISLEY & HOWLEY,

21 L.L.P., by

22 KENNETH A. TORGERSON, ESQ.

23 2500 Terminal Tower

24 50 Public Square

25 Cleveland, Ohio 44113-2241

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1 On behalf of the Defendant

2 Dr. De Blasio:

3 ULMER & BERNE, LLP, by

4 ROBERT J. LALLY, ESQ.

5 1300 East Ninth Street

6 Suite 400

7 Cleveland, Ohio 44114

8 -----

9 ALSO PRESENT:

10 ALIZABETH JAMES, Videographer

11 -----

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1 THE VIDEOGRAPHER: Good
2 afternoon, this is the videotaped
3 deposition of Dr. Louis Adler taken at
4 9876 Wilshire Boulevard, Room B in
5 Beverly Hills, California, on Friday,
6 May 5th, 2000, in the matter of
7 Patricia M. Fletcher versus Geauga
8 Hospital Association, et al., case No.
9 97 PT 0001268. This deposition is on
10 behalf of the defendant.

11 My name is Alizabeth James
12 with Lacey Video Services of Beverly
13 Hills, California. This deposition is
14 commencing at 3:13 p.m. Would all
15 present please identify themselves
16 beginning with the witness.

17 THE WITNESS: My name is
18 Dr. Louis Adler. My first name is
19 spelled L-o-u-i-s, the last name is
20 A-d-l-e-r.

21 MS. ATWELL: My name is
22 Cheryl Atwell for defendant Dr.
23 Blackburn.

24 MR. TORGERSON: My name
25 is Ken Torgerson for Dr. Howard Darwin.

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1 MR. LALLY: My name is
2 Robert Lally for defendant Dr. De
3 Blasio.

4 MR. MARGOLIS: My name is
5 Ronald Margolis for the Estate of Virgil
6 Slusher.

7 THE VIDEOGRAPHER: Would
8 you swear in the witness.

9 LOUIS ADLER, M.D., called as a
10 witness, having been first duly sworn,
11 testified as follows:

12 EXAMINATION OF LOUIS ADLER, M.D.
13 BY-MS.ATWELL:

14 Q. Dr. Adler, would you state
15 your full name and your business
16 address.

17 A. My name is Louis, L-o-u-i-s,
18 last name is Adler, A-d-l-e-r. I
19 practice with a group called Tower
20 Imaging; our office address is 8750
21 Wilshire Boulevard in Beverly Hills,
22 90211, and I also practice in hospitals;
23 at Century City Hospital which is at
24 the corner of Olympic and Century Park
25 East and at St. Johns Hospital in

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1 Santa Monica.

2 Q. Are you practicing in St.
3 Johns Hospital and Century City Hospital
4 as a part of the Tower Imaging Group?

5 A. Yes, I am.

6 Q. Have you had your deposition
7 taken before?

8 A. Yes, I have.

9 Q. On about how many occasions?

10 A. As a guess I would say
11 probably 25 to 30 times.

12 Q. I am going to give you the
13 instructions I know you have been given
14 before. If you can't hear me, tell me;
15 if you don't know what I'm talking
16 about, ask me to try it again,
17 otherwise I will presume that I made
18 some kind of sense and you can hear me
19 and know what the question is, okay?

20 A. I understand.

21 Q. And someone in here will nag
22 you to be verbal if you do "uh-huh,"
23 "uh-uh," okay?

24 A. I understand.

25 Q. I am going to ask you to

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1 give me some of your background. Start
2 with college and go through your formal
3 training after that; your residency
4 program, your fellowships and your
5 practice after that.

6 A. I was born in Havana, Cuba,
7 but came to the United States when I
8 was about six; moved to Chicago with my
9 parents, and I went to University of
10 Illinois undergraduate division in
11 Chicago for my college education. I
12 was able to enter medical school after
13 two years and went to the University of
14 Illinois, college of medicine in between
15 1968 to -- I'm sorry, between the years
16 1958 to 1962.

17 Q. Did you receive an
18 undergraduate degree?

19 A. I did not.

20 Q. So you have two years of
21 undergraduate and then went to medical
22 school?

23 A. That's what I said, correct.

24 Upon finishing medical
25 school in 1962 I was a general medical

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1 intern at Cook County Hospital in
2 Chicago from 1962 to '63; between 1963
3 and 1965 I was in the United States
4 Army as a medical officer; I was
5 stationed at Fort Louis, Washington
6 where I spent my two years there.

7 In 1965 I left the Army
8 and I started a medical residency here
9 in Los Angeles at the Wadsworth V.A.
10 Hospital. My intent at that time was
11 to become a cardiologist, however after
12 about a year in internal medicine
13 residency I decided that medicine was
14 not my forte of the area that I wanted
15 to practice in, and I switched to
16 radiology, starting a radiology
17 residency at the old Cedars of Lebanon
18 Hospital here in Los Angeles.

19 So between 1960 -- the
20 medical residency was between '65 and
21 '66; in 1966 to '69 I was a medical res
22 -- excuse me, a radiology resident at
23 Cedars of Lebanon. Between '69 and '70
24 I was asked to stay on in a fellowship
25 position at Cedars, and in 1970 I was

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1 asked to join the staff as a staff
2 radiologist at Cedars of Lebanon
3 Hospital.

4 The Cedars of Lebanon
5 Hospital then merged with the Mount
6 Sinai Hospital, and the new structure
7 was built and became Cedars Sinai
8 Medical Center, and I was part of the
9 radiology group that maintained our
10 practice at that hospital. Basically
11 from about 1975 through the current --
12 through 1992 I was a full time --
13 basically full time angiographer at
14 Cedars doing the general visceral
15 abdominal peripheral, all forms of
16 angiography other than cardiac
17 angiography.

18 In 1992 our radiology
19 group left Cedars because of contractual
20 issues, and that's when we acquired the
21 practices at Century City and at St.
22 Johns. During these last few years in
23 addition to my responsibilities of doing
24 angiography, I also do some general work
25 as well, so that's my practicing

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1 experience. I am board certified in
2 radiology, I'm a fellow of the American
3 College of Radiology. I think that's
4 my career kind of in a nutshell.

5 Q. You indicated that you are
6 board certified; when did you receive
7 your board certification?

8 A. In '70.

9 Q. Has it ever been
10 re-certified?

11 A. No, there is no designation
12 in radiology for re-certification.

13 Q. Since you started working
14 out of Century City and St. Johns
15 Hospital, your practice has changed
16 somewhat?

17 A. For me it has in that I
18 don't do 100 percent angiography, I do
19 a mixture; it's about 50 percent
20 angiography and 50 percent general work.

21 Q. When you say general work,
22 you are reading fractured bones? You are
23 reading general radiographic films?

24 A. Correct. C.T., plane films,
25 upper GI's, lower GI series, things like

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1 that.

2 Q. From the period of '92
3 through '95 do you recall what
4 experience you had or what frequency you
5 had in doing aortic angiography?

6 A. As I said, it makes up 50
7 percent of the work that I do.

8 Q. Well, 50 percent of your
9 angiography work wouldn't be aortic.

10 A. You are asking me what
11 percentage of the angiograms that I
12 do --

13 Q. Right.

14 A. -- are involved with
15 abdominal aortograms?

16 Q. Right.

17 A. I would say approximately 80
18 percent of that.

19 Q. And prior to the change in
20 '92 when your group left Cedars-Sinai,
21 how much of your work was abdominal
22 angiography?

23 A. I would say again probably
24 80 percent of that work.

25 Q. In performing abdominal

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1 angiography in the '90's, let's say,
2 what is your participation? Do you
3 insert the catheter, do you inject the
4 dye? How do you physically do it?
5 Mechanically how is it done?

6 A. With regard to the actual
7 mechanics of doing the procedure, I put
8 the local anesthetic in the skin, I put
9 the needle in the artery, I put the
10 catheter in, I attach the catheter to
11 the injector and then the technician
12 sets up the injector for the injection.
13 On occasions some of the angiography is
14 done by hand injection where I may
15 place a syringe with contrast, attach
16 that to the end of the catheter and
17 then may inject the contrast that way.

18 Over the years that I
19 have been practicing, angiography has
20 changed to some degree in that now we
21 have something called digital
22 subtraction angiography. When we didn't
23 have that everything was done on a cut
24 film.

25 With digital subtraction

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1 angiography we can use to some extent
2 smaller quantities of contrast to get
3 the same kind of information and the
4 images are readily available on the
5 monitors that we have in the room as
6 opposed to having the cut film run
7 through a processor and being developed.

8 Q. Have you been involved in
9 doing publications of research or peer
10 reviewed articles in your career?

11 A. Yes, I have.

12 Q. Are any of them particularly
13 relevant to the issues in this case?

14 A. No, they are not.

15 Q. In your career were you
16 working with residents at either
17 Cedars-Sinai or Century City or Saint --

18 A. St. Johns.

19 Q. -- St. Johns Hospital?

20 A. At Cedars, which had a
21 teaching program during the time I was
22 there, I was involved in teaching
23 residents.

24 Q. And what was your
25 involvement?

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1 A. I was teaching them how to
2 do angiography.

3 Q. Was it classroom teaching or
4 hands-on, come into the lab with me?

5 A. A combination of both.

6 Q. In the '80's and early '90's
7 how much of your time were you spending
8 as a teacher training in the resident
9 mode?

10 A. I don't know if I can
11 categorize that because it was the
12 situation during that period of time
13 that there was always a resident
14 assigned, residents would rotate
15 through, whether it was a radiology
16 resident learning how to do radiologic
17 angiographic procedures or sometimes
18 cardiology fellows that would put in to
19 rotate through the program.

20 Q. So your experience was
21 frequently there were residents in the
22 lab with you or at the patient's bed
23 side with you?

24 A. Correct.

25 Q. And it was just the norm as

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1 opposed to being something unusual?

2 A. That's correct, it was the
3 norm. It was a teaching hospital. I
4 don't think -- at this point I don't
5 think they no longer have a radiology
6 residency program; that ended shortly
7 after our group left, but I think
8 during the time that I was there
9 radiology resident teaching was the
10 norm.

11 Q. You indicated you have done
12 about maybe 25, 30 depositions; have you
13 testified in court?

14 A. Yes, ma'am.

15 Q. Do you know how often; how
16 many times?

17 A. It's a guess. I would say
18 somewhere between 6 to 12 times in
19 court.

20 Q. Of the 25 to 30 depositions
21 you have given, were all of them
22 involved in giving opinions in medical
23 malpractice litigation?

24 A. Yes, ma'am.

25 Q. When did you start doing

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1 reviews of medical malpractice claims?

2 A. It's a guess; I would say
3 it's probably the late '80's.

4 Q. Are you still reviewing and
5 accepting for review new clients?

6 A. Yes, ma'am.

7 Q. The depositions that you
8 have given and the work that you have
9 reviewed, in what states have you
10 reviewed matters or have you accepted
11 matters from?

12 A. The State of California,
13 Colorado, Texas, Missouri, Illinois.
14 That's about all I can think of right
15 now.

16 Q. In what states have you
17 provided testimony in court?

18 A. California, Colorado, Texas.

19 Q. Other than this specific
20 case, do you recall any other cases you
21 have dealt with that have been in Ohio
22 courts?

23 A. I don't believe so.

24 Q. The attorneys for the
25 plaintiffs in this case are Dan Finelli

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1 and Ron Margolis; have you worked with
2 either of these gentlemen or their law
3 firm before?

4 A. No, ma'am.

5 Q. Do you have any
6 advertisements or representations in any
7 professional literature that you are
8 available for medical/legal reviews?

9 A. No ma'am.

10 Q. What is the percentage of
11 reviews that you do for plaintiff versus
12 defendant?

13 A. It used to be 50/50, but I
14 think now though it's probably 60/40 for
15 the plaintiff.

16 Q. Have you ever been sued for
17 medical malpractice?

18 A. Yes, ma'am.

19 Q. How often?

20 A. I have received letters from
21 lawyers probably about -- again this is
22 a guess -- 12 times in the course of my
23 career so far.

24 MR. MARGOLIS: Doctor, just
25 so that I understand, I don't know what

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1 the law is in California, is a letter
2 from a lawyer the same as being sued?

3 THE WITNESS: I'm using
4 that as a phrase. Where I have had a
5 letter from a lawyer indicating that I
6 was being sued, although most of those
7 have been dropped by the way -- I would
8 say almost all of them -- I can tell
9 you about the case where there has been
10 a judgment against me was only once,
11 but all the other cases were dropped.

12 Recently -- I can tell
13 you that the last four times I received
14 a summons that I was being involved in
15 a case, that I was being sued, was that
16 in our practice we -- since I moved
17 from one location to the other in the
18 course of my practice and my other
19 partners will move also, I may be
20 called upon to look at a doctor's
21 report, my partner's report, and then
22 electronically sign it off.

23 And what's happened
24 recently is that in a number of cases,
25 at least four last time that I have

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1 gotten notices I'm being sued, my name
2 was on a report as the signature for a
3 doctor who one of my partners
4 interpreted something and subsequently I
5 had been off the case.

6 But the other cases that
7 I have been -- the two other cases
8 where I have been sued and come to a
9 point where there was either a
10 settlement or a trial, there ~~was~~ only
11 one case when I was a resident where I
12 was sued where a judgement of \$20,000
13 was found for me for supposedly missing
14 a fracture...

15 The other suits were
16 involving vascular work that I have done
17 were dismissed, and that was only one
18 that I can recall where I was sued for
19 a vascular procedure.

20 Q. What have you reviewed as a
21 part of your work in this case?

22 A. To begin with I received the
23 summary of the data referable to this
24 case that was sent to me by Mr.
25 Finelli. Then I received a copy of a

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1 report of the radiologist, a copy of
2 the surgical report from the vascular
3 surgeon, a short note from the
4 University Hospital in Cleveland
5 regarding the patient's stay at
6 University Hospital, and a copy of the
7 coroner's report.

8 Then I was given copies
9 of -- sent copies of the angiograms
10 relative to this case. Initially I was
11 sent angiograms that dealt with the
12 lower abdominal aorta and the legs, and
13 I said there had to be another series
14 available, and that was subsequently
15 found and sent to me; these included
16 films a little more proximally in the
17 abdominal aorta.

18 Q. Have you read any deposition
19 transcripts?

20 A. I have read the latest
21 deposition, and I saw a videotape of, I
22 believe it's Dr. Blackburn that I -- so
23 apparently he had two depositions taken,
24 I have not seen the first, and this was
25 the second.

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1 Q. Have you read any other
2 deposition transcripts in this case?

3 A. No other depositions. I was
4 shown a copy of two experts' letters;
5 one was the defendant's expert and then
6 one was a gastroenterologist who was the
7 expert for the plaintiff, I have seen a
8 letter from him.

9 Q. Dr. Vasalere? A guy in
10 Michigan?

11 A. From Henry Ford Hospital?

12 Q. Yes.

13 A. Yes, ma'am.

14 Q. And you have seen that. And
15 you saw Dr. Grishcan's?

16 A. Whatever, it's a one line
17 report.

18 Q. Oh, Dr. Cook's report, okay.

19 A. It was easy to remember, it
20 was one line.

21 Q. So have you received any
22 other summaries of what testimony has
23 been in this case?

24 A. I don't believe so.

25 Q. Do you have any notes that

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1 you have made as you were looking at
2 this to try to keep track of things?

3 A. The only thing that I have
4 are the two letters that I sent to Mr.
5 -- Dr. Danelli -- Finelli; yeah,
6 Finelli, regarding my interpretation of
7 the angiograms, the initial set and the
8 second set. So that's the only written
9 material that I have -- that I
10 generated.

11 Q. I have a copy of a letter
12 written by you on November 9, 1999.
13 Did you write another letter relative to
14 this case?

15 A. I did; a second letter.

16 Q. Can I see it?

17 MR. MARGOLIS: Yeah, I
18 have -- go off the record a second.

19 MR. TORGERSON:
20 Videotaped deposition off
21 record at 3:33 p.m.

22 (Recess taken.)

23 MR. TORGERSON:
24 Videotaped deposition back
25 on record at 3:35 p.m.

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1 BY MS. ATWELL:

2 Q. You handed to me your
3 earlier report of July 31, 1999 which
4 is a two page report, correct?

5 A. Yes, ma'am.

6 Q. And that is the report that
7 you wrote initially before you had the
8 additional abdominal films, correct?

9 A. That's correct.

10 Q. Do you have with you the
11 summary that you initially received from
12 Mr. Finelli?

13 A. I have that.

14 Q. May I see it?

15 A. (Handing document.)

16 MR. MARGOLIS: Let's go
17 off the record while she is reading it.

18 THE VIDEOGRAPHER:

19 Videotaped deposition off
20 record at 3:36 p.m.

21 (Recess taken.)

22 MR. TORGERSON:

23 Videotaped deposition back
24 on record at 3:37 p.m.

25 BY MS. ATWELL:

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1 Q. We took a break and you
2 handed to me a letter from Mr. Finelli
3 to you dated July 29, 1999, correct?

4 A. That's correct.

5 Q. And that was his original
6 letter forwarding the materials and a
7 summary to you?

8 A. Yes, ma'am.

9 Q. Did you do any literature
10 search relative to this case?

11 A. No, ma'am.

12 Q. Do you have in your library
13 any books or articles or materials that
14 you think have materials in them that
15 are particularly relevant to this case?

16 A. No, ma'am.

17 Q. There was no autopsy on Mr.
18 Slusher, was there?

19 A. There was a coroner's
20 report, so I don't know if that was
21 based on an autopsy or hospital records;
22 I don't know what the status is in your
23 state.

24 Q. You didn't see any autopsy
25 report, did you?

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1 A. I was not given an autopsy
2 report.

3 Q. Do you know the cause of Mr.
4 Slusher's death?

5 A. I know the cause of his
6 death based on what the surgeons found
7 at University Hospital and what the
8 coroner's report stated it as.

9 Q. And what was that?

10 A. ~~Massive necrosis of the~~
11 ~~intestinal tract from the level of the~~
12 ~~ligament of Trites to the rectum.~~

13 Q. Are you going to be
14 providing an opinion as to when that
15 necrosis occurred?

16 MR. MARGOLIS: His ~~opinions~~
17 ~~will not include the necrosis~~; they will
18 pretty much be confined to the
19 angiograms and Dr. Blackburn's
20 interpretation of them.

21 BY MS. ATWELL:

22 Q. Do you agree with that, Dr.
23 Adler?

24 A. Yes, ma'am.

25 MR. LALLY: What do you

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1 mean? So you are saying his opinions
2 are strictly limited to Dr. Blackburn?

3 MR. MARGOLIS: I think I
4 answered it relative to what Cheryl was
5 asking. Clearly if there is any
6 questions you want to ask him, you can.
7 BY MS. ATWELL:

8 Q. My understanding is you are
9 not going to attempt to provide any
10 opinions at trial of this matter
11 ~~regarding the cause of the necrosis~~; is
12 that correct?

13 A. I think my opinions relative
14 to what I interpret ~~on the angiograms~~,
15 I think that has some indication on
16 some relevance to what caused ~~necrosis~~,
17 but specifically I was asked to evaluate
18 the angiographic material that was
19 performed on this patient and that's
20 where my testimony should be involved
21 with.

22 Q. Did you see the requisition
23 or the request form that was given to
24 Dr. Blackburn asking him to get involved
25 in doing any work with this patient?

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1 MR. MARGOLIS: (Handing
2 document.)

3 THE WITNESS: It was
4 shown to me earlier today.

5 BY MS. ATWELL:

6 Q. From reviewing that
7 requisition, it's obvious that all he
8 was asked to do was to perform a
9 carotid study and a bi-femural aortic
10 study, correct?

11 A. At the top of the page it
12 says -- written in it says ~~aortic arch~~
13 ~~and carotids~~, plus a uretal bilateral
14 femural arteriogram, yes, ~~ma'am~~.

15 Q. And you would agree that
16 ~~there are various different studies that~~
17 ~~can be performed as abdominal aortic~~
18 ~~studies~~, correct?

19 A. That's true.

20 Q. And that the bilateral
21 femural arteriogram is just one study
22 that is available?

23 A. Well, it's a portion of what
24 I just described.

25 Q. Well, there are different

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1 studies that can be performed to study
2 a portion of the abdominal aorta,
3 correct?

4 A. Well, by definition the
5 abdominal aorta starts at a certain
6 point and ends at a certain point, and
7 if one is going to study the abdominal
8 aorta, one should see the beginning and
9 end of the abdominal aorta.

10 Q. Well, are there different
11 studies that are performed if the
12 concern and the reason the study is
13 being performed is there is a concern
14 there is mesenteric ischemia?

15 A. Would you rephrase that.

16 Q. ~~Are there different abdominal~~
17 ~~aortic studies that are performed if the~~
18 ~~request for the study is a concern for~~
19 ~~mesenteric ischemia?~~

20 A. Not really. I think when
21 one is looking for mesenteric ischemia,
22 one visualizes the entire aorta. ~~One~~
23 ~~may in addition to seeing it in the~~
24 ~~A.P. projection also get a lateral view~~
25 ~~if you are looking to see how stenotic~~

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1 certain vessels are.

2 Q. Do you inject the dye
3 differently or do you require different
4 dye contrasts if you are doing a study
5 of the mesenteric arteries as opposed to
6 the femoral arteries?

7 A. Well, I think you are mixing
8 up apples and oranges. If I can, I
9 would like to maybe --

10 Q. Straighten me out.

11 A. Okay. There is generally a
12 standardized volume of contrast that
13 most angiographers will use to
14 visualize the abdominal aorta where one
15 is going see it from its top at the
16 level of the diaphragmatic crus which is
17 around T12 or L1 down to the aortic
18 bifurcation and going into the iliac
19 vessels, and that generally is somewhere
20 between 40 to 50 cc of contrast.

21 When one is going to look
22 then at the vessels in the legs, one
23 either pulls the catheter down to the
24 aortic bifurcation or close to the
25 aortic bifurcation if you are coming in

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1 from a femoral approach, or as in this
2 case if you went in from an axillary
3 approach, you put the catheter a little
4 further down so it's below the renals
5 and above the aortic bifurcation, and
6 then you inject a certain quantity of
7 dye, and then take films as the table
8 moves or as the tube moves so you can
9 visualize the blood vessels from the
10 pelvis all the way down to the feet.

11 Depending upon the
12 angiographer one may use anywhere from
13 60 to 70 or 80 cc of contrast to look
14 at the runoff in both legs, meaning the
15 vessels in both legs going down as
16 opposed to the 50 -- 45 to 50 cc that
17 one uses for the abdominal aorta.

18 If one has a need to see
19 the aorta in a lateral projection and
20 if you are fortunate enough to have
21 something that is called biplane
22 angiography where you can shoot 18
23 lateral views simultaneously, you can
24 make one injection and get everything
25 done with one shot as far as the aorta

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1 both from the A.P. and the lateral.

2 If you don't have a
3 biplane capability, then it means you
4 have to use one more injection of
5 contrast with the patient viewed in the
6 lateral projection to see things in the
7 lateral. So I think that kind of
8 summarizes how you would look at the
9 abdominal aorta and the bilateral runoff
10 given that you had a patient maybe with
11 peripheral vascular disease and/or
12 possibly mesenteric disease. So, yeah,
13 you have to tailor your exam for what
14 your needs are, but you have to
15 determine what the needs are and the
16 purposes of the exam.

17 Q. And the purpose of this exam
18 was the femoral artery studies and the
19 carotid artery studies, correct?

20 A. ~~No.~~ It says here aorta, to
21 me that means they were looking at the
22 aorta as well.

23 Q. It says aorta bilateral
24 femoral arteriogram?

25 A. That's correct, aorta and .

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1 bilateral femoral arteriogram. You may
2 order just an aortogram, and I would
3 only do an aortogram. You may order in
4 a certain situation just a left femoral
5 arteriogram, I would put a needle or
6 catheter in the left femoral artery and
7 just shoot the left leg because the
8 vascular surgeon or the referring doctor
9 has said there is no indication for
10 looking at anything else. But once you
11 have aorta, then you have to look at
12 the aorta.

13 Q. So if this requisition came
14 to you saying aorta bilateral femoral
15 arteriogram, what would you interpret
16 that as requesting you to look at?

17 A. The entire abdominal aorta,
18 and then the runoff arteriogram, meaning
19 the vessels in both legs from the
20 distal aorta through the pelvis, through
21 both thighs, the knees, the calves down
22 to the feet.

23 Q. And when you talk about
24 getting the lateral projection, if you
25 don't have the machinery that can do

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1 the biplane view, you have got to
2 inject additional dye, correct, to get
3 the lateral view?

4 A. If you need a lateral,
5 right.

6 Q. And how do you determine if
7 you need the lateral as an additional
8 view?

9 A. Well, two things. One is
10 the patient's clinical history, and
11 second would be what you see on the
12 A.P. view. If the patient had symptoms
13 which were indicative of possibly
14 mesenteric ischemia and you wanted to
15 see what the origins of the celiac axis
16 and super mesenteric arteries looked
17 like, you would need the lateral in
18 order to see their take-off; their
19 origins.

20 Because in the A.P. view
21 the origins would be super-imposed upon
22 the contrast that is in the aorta and
23 you would not be able to see that as
24 well. But you can still make
25 inferences as to the status of that

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1 circulation by seeing what the films
2 look like on the A.P. projection.

3 Q. And what is it that you are
4 saying you would see on the A.P. view
5 that would cause you to get a lateral
6 view?

7 MR. MARGOLIS: You are
8 asking in general?

9 MS. ATWELL: In general.

10 THE WITNESS: When doing
11 an abdominal aortogram one generally
12 places the tip of the catheter slightly
13 above the level of the celiac axis
14 because that would be the start of the
15 abdominal aorta because the celiac axis
16 arises just below the crest of the
17 diaphragm, so it's the first intra-
18 abdominal portion of the aorta as it
19 courses through the chest and into the
20 abdomen.

21 When injecting contrast in
22 such a location, the vessels arising
23 from the aorta fill in sequence, so
24 therefore the more proximal vessels fill
25 first and the more distal vessels fill

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1 late. Now the celiac axis is the first
2 branch; it comes off of the aorta
3 anteriorly at about the level of the
4 lower portion of T12 or T12-L1
5 interspace.

6 About a centimeter below
7 that is the super mesenteric artery;
8 about a half a centimeter to a
9 centimeter below that are the two renal
10 arteries, and then lower down in the
11 abdominal aorta is the inferior
12 mesenteric artery origin which is
13 several centimeters above the aorta
14 bifurcation.

15 When looking at a series
16 of sequential films which are shot in
17 doing abdominal arteriography, and the
18 filming sequence generally is two films
19 per second for maybe four seconds, so
20 that's half a second apart, and then
21 you space them out at a second interval
22 for maybe another four or five seconds.

23 But if you are looking at
24 the films in sequence, from film No. 1,
25 say, through film No. 12, 13 or 14, in

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1 a normal individual you will see the
2 celiac axis fill first and its branches,
3 the splenic and hepatic arteries; the
4 second series of vessels that you will
5 see fill are the super mesenteric
6 because the contrast is coming to it a
7 little bit after it hits the celiac
8 axis, then the renals fill, and the
9 last thing you see fill is the inferior
10 mesenteric artery fill.

11 Now, if I see on the A.P.
12 projection the standard aortic
13 projection that there is an abnormal
14 sequence of filling of the vessels;
15 let's say the celiac axis doesn't fill
16 first but it fills later, and the SMA
17 fills and the celiac axis fills after
18 the SMA is filled, I can suspect that
19 the celiac axis is either occluded at
20 its origin or it's stenotic, and that
21 the SMA collaterals are feeding the
22 celiac axis and that's why it's filling
23 second.

24 Now, in situations where
25 the celiac axis and the SMA are both

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1 stenotic or occluded at their origin, I
2 may see -- the first thing I will see
3 filling is the renals if the renals are
4 normal. And then if there is a patent
5 or intact inferior mesenteric, on the
6 late films, when everything should have
7 been washed out, I will start see
8 filling of branches of the SMA and the
9 celiac axis, so you can infer a lot.
10 You can get a lot of information about
11 relative stenosis or obstruction of flow
12 to the visceral vessels by their phase
13 of filling.

14 Do you understand what I
15 have said?

16 BY MS. ATWELL:

17 Q. Yes.

18 A. Great.

19 Q. In this case you have seen
20 Dr. Blackburn's report from his reading
21 of the angiography on August 25, 1995,
22 correct?

23 A. Yes, ma'am.

24 Q. Do you have a copy there?
25 Or here is a copy if you don't. Here

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1 is a copy (handing document.)

2 He used a five French pig
3 tail catheter and he used a left
4 axillary approach. Do you agree that
5 it was appropriate to use the five
6 French pig tail catheter?

7 A. Yes, ma'am.

8 Q. Do you agree that it was
9 appropriate to use the left axillary
10 approach?

11 A. I only have one question
12 about that. In the request for the
13 procedure it says do as translumbar, so
14 I would question -- I would like to
15 know if it was asked to be done as a
16 translumbar aortogram, why was it done
17 as an axillary approach.

18 Not that I find anything
19 wrong with it, but I'm curious as to if
20 the referring doctor, or somebody who
21 filled this out said do this as a
22 translumbar, this was done by an
23 axillary approach.

24 Q. We have no idea who filled
25 it out, and it's different handwriting

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1 than the rest, isn't it.

2 A. I haven't checked the
3 handwriting. It says do as translumbar
4 -- do you have a copy of that?

5 Q. Yes.

6 A. All right. It says do as
7 translumbar and that's the only thing I
8 would question. Not that it's
9 inappropriate to do it as an axillary,
10 but it says translumbar here and it was
11 done as an axillary, I would say why
12 was that chosen when somebody asked you
13 to do it this way.

14 Q. Would either way be
15 appropriate?

16 A. Either way would be
17 appropriate.

18 Q. Would you agree that it was
19 -- I believe that he -- it says here he
20 placed the catheter into the abdominal
21 aorta over the renal vessels; do you
22 agree that that was an appropriate
23 placement of the catheter?

24 A. Well, that's where I would
25 take issue with you, because I think

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1 that limits the amount of the aorta
2 that you see.

3 Q. And would you agree that if
4 the angiography is being done to do a
5 femoral artery check, to study the
6 femoral arteries, that the placement of
7 the catheter over the renal vessels is
8 appropriate placement?

9 A. No.

10 Q. And why is that?

11 A. Because if I were just going
12 to look at the femoral runoff, rather
13 than putting contrast at the level of
14 where some of the contrast would go
15 into the kidneys, I would put the
16 catheter further down above the --
17 closer to the aortic bifurcation. If
18 the only thing I was interested in
19 looking at was looking at the runoff in
20 both legs, why place it at the kidneys?
21 Kidneys don't need the extra dye, it
22 has nothing to do with it.

23 No one said the patient
24 suspected -- they didn't say that he
25 suspected renal vascular hypertension,

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1 so there is no cause looking at that.
2 So I would think that if you are only
3 going to look at the runoff, then the
4 catheter should be farther down.

5 Q. Where?

6 A. It should be above the
7 aortic bifurcation, which would be below
8 the level of the renal arteries, not at
9 the level of the renal arteries.

10 Q. Do you think that any harm
11 was caused to this patient by placing
12 the catheter just above the renals as
13 opposed to just above the aortic
14 bifurcation?

15 A. I don't -- my opinion is
16 that there was inadequate information
17 gained by placing it at that level.

18 Q. Well, let's presume that the
19 purpose of the study was to obtain
20 information regarding the bilateral
21 femoral arteries. Do you think there
22 was any harm to the patient by placing
23 the catheter just above the renal
24 vessels rather than just above the
25 aortic bifurcation?

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1 A. For the purposes of just
2 looking at the runoff in both legs,
3 then I would say I agree with you, I
4 don't think there was any harm caused
5 by placing it at that level.

6 Q. From looking at the films
7 that we have from this study, do you
8 agree with Dr. Blackburn's finding that
9 the renal vessels appear to be normal?

10 A. I agree.

11 Q. Do you think it was
12 appropriate for him to advance the
13 catheter more distally to study the
14 iliac system further?

15 A. He already had that
16 information from his first position; he
17 could have left it there, he could have
18 moved it forward; I don't think it
19 makes a difference.

20 Q. Do you agree with Dr.
21 Blackburn that there was a completely
22 occluded right iliac artery?

23 A. No. I disagree.

24 Q. What do you believe the
25 right iliac artery shows?

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1 A. I think that the films are
2 mis-labeled. I think the left is
3 really the right side, and he in his
4 report -- he wasn't aware that the
5 films were mis-labeled. He was reading
6 right was left and left was right and
7 he was wrong; it was 180 degrees off.

8 Q. In your hospital is the
9 right and left labeling on the film, is
10 that loaded into the computer by a
11 technician?

12 A. No.

13 Q. You load that into the
14 computer?

15 A. No.

16 Q. How is it put into the
17 computer?

18 A. It's not always on the
19 computer. Sometimes it's on cut film
20 like this, and on cut film the
21 technician puts a marker on it. As far
22 as on the digitals it's usually done by
23 the tech who also loads it into the
24 computer.

25 Q. Do you agree with Dr.

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1 Blackburn that one of the iliac arteries
2 was completely occluded?

3 A. I think Dr. Blackburn called
4 the wrong iliac artery completely
5 occluded. What was completely occluded
6 was the left and not the right.

7 Q. Do you agree with him that
8 the other iliac artery had 70 percent
9 stenosis?

10 A. I think that the other iliac
11 artery was significantly stenotic, the
12 common iliac, and then there was an
13 occlusion of the right external iliac
14 and common femoral artery.

15 Q. Do you agree with Dr.
16 Blackburn's finding that there was
17 severe atherosclerotic occlusive disease
18 found in his aortic bi-femoral
19 arteriogram study?

20 A. I think by definition the
21 patient had severe atherosclerotic
22 disease and showed evidence of
23 occlusions of the left common iliac,
24 external iliac and common femoral
25 artery, and the right external iliac and

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1 common femoral artery.

2 Q. Would you agree that those
3 occlusions and stenosis are consistent
4 with the clotication symptoms that this
5 patient had?

6 A. I wasn't aware of his
7 clotication symptoms.

8 Q. Looking at the requisition
9 for work on this, it indicates
10 diagnosis, carotid stenosis and
11 clotication, correct?

12 A. That's what it says there.

13 Q. Would you agree that the
14 findings of the stenosis and occlusions
15 of the iliacs is consistent with the
16 clotication that was indicated in the
17 requisition for this arteriogram?

18 A. Yes, ma'am.

19 Q. Do you have any criticisms
20 of Dr. Blackburn's reading of the
21 carotid arteriogram?

22 A. I have never seen the
23 carotid arteriogram.

24 Q. Oh, you haven't? You didn't
25 see the actual films?

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1 A. I have never seen the
2 carotid portion of the study --

3 Q. Okay.

4 A. -- so I can't tell you one
5 way or the other.

6 Q. Okay.

7 Would you agree that the
8 stenosis and occlusion seen in the
9 arteriogram films that you saw are
10 more likely than not related to Mr.
11 Slusher's 30 year smoking history?

12 MR. MARGOLIS: Objection.

13 THE WITNESS: I don't
14 know.

15 BY MS. ATWELL:

16 Q. Is there any other
17 information you need to be able to
18 answer that question?

19 A. His family history.

20 Q. As a general rule do you
21 consider smoking history to be relevant
22 and a causative force for
23 atherosclerotic disease?

24 A. I agree with you. As a
25 general rule I think significant smoking

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1 history has a role to play in patients
2 who have atherosclerotic disease.

3 Q. What is the risk of
4 performing an aorta bi-femoral
5 arteriogram?

6 A. I think it -- as a general
7 rule I will tell you I think that the
8 risk is relatively low. I think that
9 the risk tends to be associated with
10 the approach used to do the arteriogram.

11 The risk of complications
12 from doing abdominal arteriography or
13 aortography by a femoral artery approach
14 is probably less than one or maybe half
15 of one percent by either causing damage
16 to the artery in the groin, getting
17 some bleeding or hematoma afterwards.

18 The risk of doing a
19 transaxillary abdominal -- using a
20 transaxillary approach for the same
21 procedure I think is higher, especially
22 in the patient who has a history of
23 significant atherosclerotic disease as
24 this patient had because the same
25 atherosclerotic process may be involving

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1 the axillary and subclavian arteries.

2 It's possible sometimes
3 that traversing the subclavian vessel
4 with the catheter that a stroke can
5 occur; also hemostasis after doing the
6 procedure because sometimes it's
7 difficult and it's not uncommon for
8 patients to develop hematomas in the
9 axilla or have plexus problems, so that
10 has some added risk in using the
11 axillary approach.

12 The translumbar approach,
13 although it sounds rather relatively
14 more difficult because you are going in
15 from the back and you are putting the
16 catheter and needle directly into the
17 aorta, also has a relatively low risk
18 rate to it. Probably the risk of a
19 complication meaning a hematoma in the
20 rectal perineal area after doing the
21 procedure is probably one to one and a
22 half percent and usually those are
23 pretty self-limited.

24 So again it depends on
25 the approach. So the lowest risk rate

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1 is doing it femurally. The patient,
2 you couldn't do him femurally because of
3 his occlusions, so you are left with
4 using translumbar if you are comfortable
5 doing that, or using axillary which has
6 a somewhat higher incidence of risk to
7 it.

8 Q. Is there any risk associated
9 to the dyes that have to be injected
10 for the studies?

11 A. With contrast material there
12 is always the question of risk of
13 allergy, an allergic reaction, and
14 depending upon the patient's renal
15 function some contrast can sometimes
16 make the renal function worse.

17 In those patients who are
18 diabetic or who have impaired renal
19 function to begin with, the contrast
20 load can either temporarily or
21 permanently make renal function
22 impaired.

23 Q. Is there any parameter that
24 invasive radiologists use for the amount
25 of contrast material they want to use

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1 when doing a study on an individual?

2 MR. MARGOLIS: I object
3 and ask, is this a healthy individual
4 or an individual with renal disease? I
5 don't understand your question, I ask
6 you to specify.

7 BY MS. ATWELL:

8 Q. Would your answer be
9 different depending on whether the
10 patient had renal disease or not?

11 A. Yes.

12 Q. Okay. Tell me both ways.

13 A. In a patient who has no
14 evidence of renal function, renal
15 function abnormality, one can use
16 probably up to maybe 200 to 300 cc of
17 contrast to do a study and the patient
18 should be able to tolerate it, although
19 most studies can be done with
20 significantly less than that amount, if
21 you are talking about doing an abdominal
22 aortogram or arteriogram.

23 In a patient who has
24 impaired renal function where you --
25 let's say you get a serum keratin as a

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1 measure of how well the kidneys are
2 working; if the keratin is above the
3 normal level for the hospital range that
4 you are in, I think you have to limit
5 the amount of contrast that you use;
6 you want to maybe get the procedure
7 done with maybe 100 cc of contrast or
8 somewhere in that range as opposed to
9 using 200 or more.

10 So I guess you have to --
11 I can't give you a hard and fast number
12 because you have to look at each
13 individual. Is the patient's keratin 4;
14 is he going to go onto dialysis anyway,
15 then you do whatever you have to do; is
16 he borderline as far as renal function.

17 I think that's where you
18 have to talk to the referring doctor,
19 the patient's primary care physician,
20 his nephrologist if he has one, and
21 make a decision what do they think he
22 can tolerate as far as contrast load.

23 Q. In this patient, because he
24 was having both a carotid arteriogram
25 simultaneously with the femoral

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1 arteriogram, that would cause him to
2 have more dye injected, correct?

3 A. If you are doing it all on
4 cut film, I agree; but I think that the
5 carotids were done on digital and a
6 portion of the aorta was looked at on
7 digital, so with digital you use
8 significantly less contrast, so you do
9 save contrast by using the digital
10 technique.

11 Q. If you are the invasive
12 radiologist doing this double study,
13 both the carotids and the femurals, one
14 of things you do have to be concerned
15 about is the amount of time you have
16 this patient on the table and the
17 amount of dye you are injecting -- the
18 amount of contrast material you are
19 injecting, correct?

20 A. I don't know what I what you
21 mean by time. I think that it's
22 important to have the patient on the
23 table for as long as it takes to get
24 the information that is needed. So you
25 would like not to keep the catheter in

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1 a small vessel longer than you have to,
2 but if that's your means of access,
3 then you are there, you bite the bullet
4 and you keep the patient there as long
5 as you get all the information that is
6 necessary.

7 The contrast again is
8 determined -- the volume of contrast is
9 determined by the patient's hydration,
10 renal function, cardiac status, and I
11 think all those things are taken into
12 consideration when doing procedures such
13 as that, but it's not uncommon to be
14 able to do arch and carotids and then
15 do the aorta and runoff on a patient if
16 he has multiple levels of vascular
17 pathology that have to be looked at and
18 all done safely in one study.

19 Q. How much contrast material
20 would be necessary to do the combined
21 carotids, the arch, the entire aortic
22 study as well as the femoral runoffs?

23 MR. MARGOLIS: With digital
24 technology or without?

25 BY MS. ATWELL:

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1 Q. Either way.

2 A. Using a combination of
3 digital and cut film -- let's say we
4 did the arch on digital with a selected
5 carotid injection, you can take the arch
6 with 20 cc and the selected carotid
7 with 10 -- this is diluted contrast,
8 okay -- you then put the catheter down
9 into the abdominal aorta, you can do
10 the abdominal aorta on digital with 20
11 or 25 cc, then you can put the catheter
12 down at the aortic bifurcation and do
13 the runoff with 56 to 60 cc.

14 Q. What would cause more
15 contrast to be necessary so that you
16 are using the 200 to 300 cc that you
17 mentioned earlier for doing the two
18 studies?

19 A. If you find areas in your
20 study that aren't visualized adequately
21 and you have to make additional
22 injections.

23 Q. The inferior mesenteric
24 artery supplies blood supply to what
25 portions of the anatomy?

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1 A. The inferior mesenteric
2 artery supplies the blood supply
3 primarily to the descending colon from
4 the splenic flexure down to the sigmoid
5 colon and rectum and to a small portion
6 probably of the distal transverse colon,
7 so it's probably about half the colon
8 and the rectal sigmoid colon.

9 Q. What part of the anatomy is
10 supplied blood by the superior
11 mesenteric artery?

12 A. Super mesenteric artery
13 supplies blood to the entire small bowel
14 from the ligament of Trites which is
15 just beyond the duodenum, or where the
16 duodenum becomes the jejunum, to the
17 secum, ascending colon and transverse
18 colon to the point where the
19 transition point is where the IMA takes
20 over.

21 Q. What portion of the anatomy
22 is supplied by the super --

23 A. By the celiac axis.

24 Q. Okay, the celiac axis?

25 A. Celiac axis provides blood

1 supply to the spleen, the stomach, the
2 duodenum, the liver, the galbladder, the
3 pancreas, and a portion of the distal
4 esophagus.

5 Q. Really distal.

6 A. Right. The lower part of
7 the esophagus. The remaining portion of
8 the esophagus is supplied by branches of
9 the thoracic aorta and branches of the
10 inferior carotid artery.

11 Q. And the superior hemorrhoid
12 artery, what does that supply?

13 A. The superior hemorrhoidal
14 artery is a continuation of the inferior
15 mesenteric artery which goes down and
16 supplies the distal sigmoid colon and
17 rectum.

18 Q. Would you agree that the IMA
19 is not the dominant blood supply path
20 to the colon?

21 A. No, I disagree.

22 Q. In comparing the SMA to the
23 IMA, can you compare their importance or
24 the volume of blood that they supply to
25 the colon?

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1 A. Well, I think you have to
2 look at the colon is supplied by two
3 blood vessels; one is the superior
4 mesenteric artery which supplies the
5 secum, ascending colon and most of the
6 transverse colon; and then the distal
7 portion of the colon, meaning from the
8 distal transverse colon through the
9 splenoflexure, descending colon, sigmoid
10 colon, rectum is supplied by the
11 inferior mesenteric artery. So the SMA
12 supplies a half to maybe the colon and
13 the IMA supplies the other half of the
14 colon.

15 Q. Would you agree that it's
16 more frequent to see occlusion or
17 stenosis of the IMA than occlusion or
18 stenosis of the SMA?

19 A. I would agree; somewhat
20 slightly more increase incidents.

21 Q. And why is that?

22 A. Because most of the
23 atherosclerotic disease in the abdominal
24 aorta is below the level of the renal
25 arteries. For some reason the aorta

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1 above the renal arteries, meaning up to
2 the level of diaphragm is -- although
3 it has atherosclerotic changes in it,
4 they don't become as severe as in the
5 lower portion of the abdominal aorta,
6 meaning that portion below the renals.

7 It's thought by some
8 people that the reason that the distal
9 abdominal aorta becomes more
10 atherosclerotic is because it's closer
11 to the vertebral column at that point,
12 and the combination of the pulsation of
13 the aorta up against the vertebrae
14 causes more atherosclerosis to develop.
15 Now since the IMA is the branch of the
16 lower -- below the level of renal,
17 there is an area where there is more
18 atherosclerosis and therefore it is more
19 prone to develop stenosis at its origin.

20 Q. Would you agree that more
21 frequently when the IMA is found to
22 have atherosclerotic disease, the SMA
23 and the celiac axis don't have the
24 atherosclerotic disease; would you agree
25 with that?

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1 A. No.

2 Q. Are you familiar with any
3 studies or in your own practice
4 comparisons of those vessels?

5 A. Well, I can tell you my
6 experience over the number of years that
7 I have been doing angiography, and I
8 have done a lot of visceral angiography
9 with regards to looking at the celiac,
10 the SMA and the IMA vessels. That
11 although atherosclerotic changes can
12 occur at the origins of the celiac and
13 the SMA, I don't think that they are
14 any less frequent than they are in the
15 IMA.

16 The difference is that we
17 are dealing with larger vessels to begin
18 with. The celiac and the SMA are
19 significantly bigger vessels than the
20 IMA, and therefore an atherosclerotic
21 plaque at the origin of a small vessel
22 can cause more problems than a little
23 bit of plaqueing or whatever at -- or
24 similar process at the origin of a
25 large vessel.

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1 As to kind of go a little
2 further, the renal arteries are very
3 frequently involved by atherosclerotic
4 plaques that cause permanent blood flow
5 into the kidneys. Sometimes these
6 atherosclerotic plaques are inside the
7 renal arteries themselves, but often
8 they can be at the origins of the renal
9 arteries as they come off from the
10 aorta.

11 Depending on how big the
12 aorta -- the renal arteries at its
13 origin, will depend on how much of a
14 stenosis is there. So again I think
15 you -- I think you can fall into a trap
16 by making too broad of a generalization
17 by saying that you see one more than
18 the other.

19 Q. Would you agree that the IMA
20 can be occluded while the SMA and the
21 celiac axis remain patent?

22 A. Yes, that can happen.

23 Q. Would you agree that more
24 often than not the IMA has disease
25 while the SMA and the celiac axis

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1 remain patent?

2 A. Well, I'm not sure where the
3 disease is, so I can't tell you. I
4 don't know if the disease is because
5 the aorta has a plaque which occludes
6 the IMA origin or is it the IMA itself
7 that has become diseased; I don't know.

8 Q. Would you agree that more
9 often than not if the IMA is occluded
10 or has stenosis, there is a remaining
11 blood flow through the SMA and through
12 the celiac axis?

13 A. I think in most instances
14 there are, as long as there is a patent
15 celiac and SMA to provide the
16 collaterals. The celiac is not as
17 important as the SMA is to providing
18 the collaterals to the left colon when
19 there is an IMA occlusion.

20 Q. Would you agree that more
21 often than not the SMA is patent when
22 the IMA has an occlusion or stenosis?

23 A. I don't know how to answer
24 that.

25 Q. And do you need more

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1 information? Do I need to reword --
2 why do you say "I don't know how to
3 answer that"?

4 A. Because I would have to look
5 at your information, where you are
6 coming from and what series of cases
7 you are looking at. I think that the
8 IMA can frequently be occluded either
9 due to surgery, or say in a patient
10 that had a femoral artery bypass graft,
11 or in a patient who has asymptomatic
12 atherosclerotic disease.

13 If the patient is not
14 exhibiting symptoms of visceral
15 impairment to the left colon -- vascular
16 impairment to the left colon, then I am
17 assuming that the collaterals in the SMA
18 are patent. As I said before, you may
19 have atherosclerotic disease at the
20 origin of the celiac and the SMA, but
21 because the origins are bigger, that it
22 takes a lot more plaqueing to cause
23 significant stenosis.

24 So if the IMA goes and
25 the SMA is still patent, the SMA is

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1 going to provide the collateral flow.
2 So most of the time that's true, but it
3 doesn't always exist. It depends on --
4 each individual is a little bit
5 different.

6 Q. Can the bowel remain viable
7 when it's only receiving its blood flow
8 from one vessel, just the SMA?

9 A. In patients who have
10 abdominal angina or bowel ischemia, it's
11 thought to be a general rule that two
12 vessels have to be gone out of the
13 three, the three main vessels, so if
14 the celiac and the SMA are gone and you
15 are left with the IMA or some
16 combination, in order to get symptoms --
17 the degree of viability depends upon
18 factors which I don't have the
19 information on.

20 I mean I know that
21 patients will complain of either
22 abdominal pain, weight loss, some
23 patients may have diarrhea because they
24 have ischemic bowel symptoms; they
25 haven't infarcted their bowel yet but

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1 they have some changes in the physiology
2 of the bowel, because just as a patient
3 who doesn't have enough blood going to
4 his legs cloticates, the bowel is
5 clotivating when it doesn't get enough
6 blood; meaning if it only has one
7 vessel supplying blood when three should
8 be supplying blood, then the bowel gives
9 you symptoms. So I hope I answered
10 your question. I am trying to give you
11 the background on that.

12 Q. Would you agree that
13 invasive radiologists don't diagnose
14 mesentery ischemia?

15 A. Do we diagnose it after we
16 do the angiogram? Yeah, we do. Do I
17 diagnose it before, because I haven't
18 seen the patient, you know, before the
19 angiogram because he hasn't come to me
20 as a primary care physician, but I can
21 make an inference from looking at the
22 angiogram that the patient could
23 possibly have mesenteric ischemia.

24 Q. Mesenteric ischemia is
25 actually a clinical diagnosis, correct?

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1 A. I think that the clinician
2 would say yes. I think this patient
3 has ischemic bowel syndrome.

4 Q. And the arteriogram either
5 corroborates it or doesn't corroborate
6 it, but cannot diagnose it, wouldn't you
7 agree with that?

8 A. No. Because if I'm
9 corroborating a physician's suspicion,
10 then I am making a diagnosis.

11 Q. Would you agree that an
12 occlusion of the -- an occlusion or a
13 stenosis of the iliac vessels can be
14 consistent with a number of processes?

15 A. I don't understand you.

16 Q. Okay.

17 MR. MARGOLIS: We have
18 been going for about an hour and 15
19 minutes, Doctor. If at any time you
20 want to take a break, just say we want
21 to have a break.

22 MS. ATWELL: We are
23 having such a good time.

24 THE WITNESS: I want to
25 make sure she catches her plane.

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1 MS. ATWELL: Let's do it
2 now.

3 THE VIDEOGRAPHER:
4 Videotaped deposition off record at 4:14
5 p.m.

6 (Recess taken.)

7 MR. TORGERSON:
8 Videotaped deposition back on record at
9 4:26 p.m.

10 BY MS. ATWELL:

11 Q. If the inferior mesenteric
12 artery is prominent, is that consistent
13 with the iliac occlusions and stenosis
14 found in this gentleman?

15 A. Not necessarily.

16 Q. Well, can it be consistent
17 with that?

18 MR. MARGOLIS: Objection as
19 to "can." I think the standard we are
20 all under is more probable than not.

21 MS. ATWELL: Well, I can
22 start with "can."

23 MR. MARGOLIS: Objection.

24 THE WITNESS: I think
25 it's possible but not likely.

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1 BY MS. ATWELL:

2 Q. And why do you say not
3 likely?

4 A. Because I think that
5 although the inferior mesenteric artery
6 and its super hemorrhoidal branch could
7 possibly be a source of collateral blood
8 supply to an occluded iliac artery,
9 there are other more prominent ways of
10 supplying collateral blood flow that
11 have a role in supplying collateral
12 blood flow to an iliac artery occlusion
13 than the super hemorrhoidal artery.

14 Q. Well, is the superior
15 hemorrhoidal artery one of the primary
16 collateral pathways to the iliac
17 vessels?

18 A. No.

19 Q. Is it one of the primary
20 collateral pathways to the colon?

21 A. It's not collateral, it's a
22 primary branch that goes down and feeds
23 the rectus sigmoid. It's not a
24 collateral, it's the vessel that goes
25 down there to feed it.

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1 Q. With the iliac occlusion and
2 stenosis that was found in this
3 gentleman, what would you expect to see
4 happening with the other arterial
5 vessels?

6 A. Well, I think the vessels
7 that are supplying the iliacs would
8 become prominent.

9 Q. And what are they?

10 A. The lumbar which are
11 branches off the abdominal aorta; in
12 cases of iliac artery occlusion or in
13 fact aortic occlusion, the anterior
14 epigastric arteries become collaterals
15 and enlarged that supply collateral
16 blood flow to the iliac and femoral
17 arteries.

18 Q. Anything else?

19 A. Those are the main sources
20 of collateral flow.

21 Q. And in this gentleman we can
22 see on the films that the lumbar is
23 enlarged, correct?

24 A. We see one left lumbar
25 that's enlarged, and you can see it

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1 actually filling the portion of the left
2 internal iliac artery.

3 Q. And you consider that just
4 to be consistent with the iliac process
5 that's going on?

6 A. Yes, ma'am.

7 Q. What do you believe was the
8 cause of the -- let me back up.

9 How would you describe the
10 IMA as shown on the films for this
11 gentleman?

12 A. I think the IMA is
13 prominent.

14 Q. And what does prominent
15 mean?

16 A. Larger than normal.

17 Q. Is there some kind of graded
18 scale of language that you use to
19 describe these vessels; normal,
20 prominent, markedly prominent, dilated?

21 A. Well, to answer that I would
22 say I know what the size -- or what a
23 normal inferior mesenteric artery should
24 look like, and I know how apparent its
25 branch vessels should be. When it is

1 larger, meaning when I can see the
2 artery being bigger in caliber, in
3 diameter, compared to what a normal
4 artery would look like, then I just say
5 that it's prominent, it's enlarged.

6 I don't grade it by grade
7 1, grade 2, grade 3 or grade 4, I just
8 know normal or prominent or absent.

9 Q. And those are the only terms
10 that you use to describe the inferior
11 -- the -- yeah, inferior mesenteric
12 artery?

13 A. That's all I use.

14 Q. Okay. Let's look at some of
15 these films. In fact, I'm going to
16 turn off a portion of the overheads
17 just to get a little better contrast
18 here.

19 (Discussion off record.)

20 BY MS. ATWELL:

21 Q. Using your pencil -- no, you
22 use it.

23 A. Okay.

24 Q. Well, let me use it.

25 A. Yes, ma'am.

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1 MS. ATWELL: Are you
2 focused in on the film?

3 MR. MARGOLIS: If you can
4 identify it first.

5 BY MS. ATWELL:

6 Q. We are looking at a film
7 that's labeled Image 9 for Virgil
8 Slusher from August 25, 1995, correct?

9 A. Yes, ma'am.

10 Q. And we are looking at a
11 portion of the abdominal aortogram,
12 correct?

13 A. Yes, ma'am.

14 Q. And this is the aorta,
15 correct?

16 A. Yes, ma'am.

17 Q. And what vessel is this
18 right here?

19 A. It's the left renal artery.

20 Q. And right here we can see a
21 lighter contrast vessel; do you know
22 what that vessel is?

23 A. Is this a test?

24 Q. Yes, this is a test.

25 A. It's the right renal artery.

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1 Q. And right here we have even
2 a fainter contrast vessel; do you know
3 what vessel that is?

4 A. I'm not sure.

5 Q. Is it possible that that's
6 the superior mesenteric artery?

7 MR. MARGOLIS: Objection as
8 to possibility.

9 THE WITNESS: I don't
10 believe so.

11 BY MS. ATWELL:

12 Q. Why not?

13 A. That's not where the
14 superior mesenteric artery goes.

15 Q. And why do you say that?

16 A. Because I have seen a lot of
17 superior mesenteric arteries over the
18 years.

19 Q. This is an A.P. view,
20 correct?

21 A. Yes, ma'am.

22 Q. And if you were trying to
23 actually study this vessel, you would
24 need to get a different view, correct?

25 A. Not necessarily.

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1 Q. What else could you do?

2 A. Pull the tip of the catheter
3 up closer to that vessel and inject
4 some dye so I could see it better.

5 Q. So do you have any
6 reasonable conclusion as to what vessel
7 that is?

8 A. I'm not sure. It's possible
9 that given its location, it's going off
10 to the right side, that it's an
11 accessory renal artery; maybe it's
12 another renal. Could it be a portion
13 of -- could it be a branch of the
14 celiac? Could it be a branch of the
15 SMA? It's not the main SMA.

16 Q. Coming down here to the
17 lower portion of this figure, right here
18 we appear to have a vessel coming off
19 the aorta, correct?

20 A. Yes, ma'am.

21 Q. Do you believe that this
22 attachment here is the vessel that keeps
23 on going down?

24 A. Yes, ma'am.

25 Q. What vessel do you believe

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1 that is?

2 A. That's the inferior
3 mesenteric artery.

4 Q. And then we have another
5 vessel that seems to ascend and cross
6 over; what is that vessel?

7 A. It's the lumbar.

8 Q. And coming off the IMA and
9 ascending is another vessel; what is
10 that?

11 A. I think that -- you know,
12 the terminology varies depending upon
13 usage and about whose doing it, but I
14 would call it the marginal artery.
15 It's a continuation of the IMA trunk
16 going in a cephalic direction.
17 Sometimes they will refer to it as a
18 marginal artery, a drumond, some will
19 refer to it in other ways. So we don't
20 get lost in semantics, I will just call
21 it the marginal artery.

22 Q. What is the difference
23 between the marginal artery and the
24 marginal artery of drumond?

25 A. By definition the marginal

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1 artery becomes the marginal artery of
2 drumond when it acts as a collateral
3 blood supply or a source of collateral
4 blood flow.

5 Q. And when it acts as that
6 collateral blood supply, is it correct
7 to say that it joins with some of the
8 other branches of the vessels that come
9 off the IMA?

10 A. Well, it doesn't join with;
11 it gives off branches that feed the
12 colon; that's part of its job. But the
13 fact that it has become enlarged or its
14 now acting as a collateral, that means
15 that it's continuation to its final
16 destination which is the superior
17 mesenteric artery is being utilized by
18 this vessel.

19 Q. And going on down Image 9 to
20 the bottom of that image, what am I
21 pointing to here?

22 A. Probably the beginning
23 portion of the right common iliac artery
24 as it comes off in the distal aorta.

25 Q. Looking at the renal that we

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1 clearly see and the other lighter
2 contrast which is probably a renal, you
3 agree that the renals are patent here?

4 A. They are patent. There is
5 some minor plaqueing, but they are
6 patent.

7 Q. Looking at the IMA on this
8 film, how do you describe that?

9 A. Well, I think it's
10 prominent. It's larger in caliber than
11 I would normally see. Also it's
12 interesting when you look at this film,
13 the density of the contrast in the IMA
14 is not as dense as that in the aorta or
15 the lumbar.

16 Q. And what explains that?

17 A. That somehow it's not
18 getting as much contrast per unit volume
19 as the lumbar or the aorta relative to
20 where the contrast is being injected.

21 Q. Could that also be related
22 to whether or not this is a picture
23 that is taken 12 seconds after the dye
24 that's injected as opposed to six
25 seconds after the dye was injected?

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1 A. No, because what I'm looking
2 at is, I'm looking at relative amount
3 of contrast here, relative amount of
4 contrast in this vessel; if I'm looking
5 at the origin of this vessel, it
6 doesn't look as dense as these other
7 two vessels, so to me I would have to
8 kind of scratch my head and say what is
9 causing that. Why isn't this portion
10 of the IMA which is coming right off of
11 this dense aorta as dense as the aorta?

12 Why is this lumbar -- if
13 you are looking at this portion of the
14 lumbar a little bit further out here,
15 why is that denser than anywhere else?
16 I'm not sure, you know, I could ~~tell~~
17 ~~you what it is,~~ but ~~I would just look~~
18 ~~at it and make kind of a mental note of~~
19 ~~it.~~

20 Q. Would you agree ~~that one of~~
21 ~~the reasons that the celiac axis is not~~
22 ~~shown here and that the SMA is not~~
23 ~~shown here, as you believe, is because~~
24 ~~of the placement of the catheter?~~

25 A. ~~Right,~~ the catheter -- here

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1 is the tip of the catheter right here.
2 You can see the pig tail, this curve,
3 and the contrast in a pig tail catheter
4 tends to come out right at where this
5 coil is rather than going more proximal.

6 Q. Because the little holes in
7 the catheter are --

8 A. Are right at the curve,
9 correct.

10 Q. So it just comes out and
11 drops down.

12 A. Correct.

13 Q. The ~~maneuver~~ fact that the
14 celiac axis and the SMA are not shown
15 clearly on this film doesn't mean that
16 they aren't there ~~and that they aren't~~
17 ~~operating correctly?~~

18 A. We ~~have no idea.~~ I can't
19 tell you ~~one way or the other.~~

20 Q. Let's look at --

21 MR. MARGOLIS: Cheryl, you
22 had a 50/50 shot of putting up right.
23 I was on your side.

24 BY MS. ATWELL:

25 Q. This is another film from

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1 Mr. Slusher from August of 1995,
2 correct?

3 A. Yes, ma'am.

4 Q. And this is the film that
5 shows a lower portion of his body with
6 the femoral runoff down in the pelvic
7 area, correct?

8 A. Correct. And we don't see
9 the renal arteries.

10 Q. Because it's lower?

11 A. (No audible response.)

12 Q. Yes?

13 A. (No audible response.)

14 Q. You have to say yes.

15 A. Yes, ma'am.

16 Q. And what are we seeing here?

17 A. We are seeing, first of all,
18 the ~~mis-~~labeling of the film with this
19 side saying "left" when it should be
20 right, and the reason I know that is
21 because the ~~inferior mesenteric artery~~
22 ~~always comes off toward the left side~~
23 ~~of the aorta~~, comes off anterior and to
24 the left as opposed to the anterior and
25 to the right, without a doubt. I have

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1 seen a lot of anomalies in my time
2 doing angiography and radiology, but
3 this is never an anomaly.

4 Q. And you would agree that
5 there is a lot of variation from one
6 human being to another on how the
7 arteries appear; how large they are, the
8 exact placement of the vessels and the
9 branching off of them?

10 A. I would not agree with that.
11 I would say there is ~~some~~ variation,
12 but not a lot.

13 Q. Okay.

14 A. Okay?

15 And to continue what you
16 are asking me, what we are seeing is
17 the distal abdominal aorta, the right
18 common iliac with its area of stenosis
19 and plaqueing. More proximally,
20 portions of the inter-iliac artery on
21 the right side, the occlusion or lack
22 of filling of a left common iliac
23 artery, no external iliac or common
24 femoral on either side, and then we see
25 a big lumbar coming off, and you can

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1 see this little kind of tortuosity of
2 vessels right here, and then you see a
3 portion of the right internal iliac
4 artery filling.

5 You see the inferior
6 mesenteric artery coming off the distal
7 aorta, its marginal artery going up with
8 its branches toward the left colon, and
9 the superior hemorrhoidal branch coming
10 down, and then dividing into the two
11 branches that go around the rectum, and
12 a little bit of contrast in the
13 bladder.

14 Q. How would you describe the
15 appearance of the superior hemorrhoidal
16 artery?

17 A. Slightly prominent.

18 Q. Now, you --

19 A. It's prominent; prominent.

20 Q. You put a qualifier on
21 there.

22 A. Okay, I will take it back.

23 Q. Why did you call that
24 slightly prominent?

25 A. I don't know. I made a

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1 mistake.

2 Q. Come on, you didn't make a
3 mistake, you thought it was slightly
4 prominent.

5 A. I made a mistake. I told
6 you I say it's either prominent or not
7 prominent; it's prominent.

8 Q. Why do you call it
9 prominent?

10 A. ~~Because normally it should~~
11 ~~be a much smaller vessel.~~ The IMA and
12 its branches generally are in the range
13 of three to four millimeters in size,
14 and I think this is larger than three
15 to four millimeters.

16 Q. Is it possible looking at
17 film to actually measure it with any
18 tool and with any certainty be able to
19 determine whether that vessel is within
20 the normal range or the abnormal range?

21 A. You have to take a count
22 magnification when you do an angiogram
23 because there is some magnification
24 depending upon where the distance of the
25 tube is to the film. You can put -- if

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1 you needed to be exact you can put some
2 kind of calibration device on the film
3 and measure that to the calibration
4 device.

5 But, you know, for general
6 purposes you take a centimeter ruler and
7 measure the size of the vessels. Then
8 you also rely on your experience; what
9 have you seen over a period of one year
10 in practice, five years in practice or
11 20 years in practice.

12 Q. Normally a radiologist does
13 not do the mathematical calculation
14 taking into account the magnification
15 and all of that to determine whether or
16 not the vessel size is normal or --

17 A. Yeah, I would say it's rare
18 that I would do that. I would base it
19 on my experience visualizing the vessels
20 on the films.

21 Q. Okay. Looking at a third
22 sheet of film, is there anything on
23 this sheet of film which shows the six
24 views with a smaller surface area for
25 those six views that is not shown on

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1 the Image 9 and Image 10 film that we
2 already looked at that you think should
3 be drawn to our attention?

4 A. I don't think there is any
5 additional information that we gain from
6 looking at Image 9 -- that's 9, and
7 Image 10 versus looking at this. The
8 only thing we can tell you from here is
9 if you look --

10 Q. Which is Image 6.

11 A. -- starting with Image 6,
12 you can see how if you look at things
13 in a sequential manner, you can see the
14 aorta being filled up at this point,
15 then filling a little bit more here, a
16 little bit more here, and as the
17 contrast comes down everything becomes
18 denser, right, because these are done at
19 probably --

20 Q. Sequential.

21 A. -- sequential. That's about
22 it. I don't think you can gain
23 anything more out of that than looking
24 at that and seeing what a sequential
25 fill up of contrast looks like in a

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1 blood vessel.

2 Q. Okay. I am going to ask our
3 videographer to pull back away from the
4 film and I will turn the other light
5 back on.

6 If the IMA is the only
7 blood flow source to the colon, what do
8 you expect the IMA and the marginal
9 arteries to look like?

10 A. If it were the only source
11 of blood flow?

12 Q. Yes. Right.

13 A. I would expect it to be
14 prominent.

15 Q. Anything else?

16 A. I think it depends on the
17 patient's individual anatomy as to how
18 prominent the vessel would be, and I
19 think you have to be able to see the
20 entire course of the vessel to make a
21 judgment.

22 Q. Do you expect it to be more
23 tortuous, more twisting?

24 A. It may or may not be. I
25 think again it's an individual -- it

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1 depends on the patient.

2 Q. If the SMA has high grade
3 stenosis or is occluded, what do you
4 expect to see as far as collaterals or
5 other changes in the vessels in an
6 arteriogram?

7 A. If the SMA were occluded and
8 the celiac is patent?

9 Q. Yes.

10 A. So I ~~have~~ got the celiac
11 patent and I ~~have~~ got the IMA patent
12 but the SMA is occluded.

13 Q. Right.

14 A. Either ~~through collaterals~~
15 from the celiac axis, or from the
16 ~~collaterals from the IMA~~ I would see
17 late filling of branches in the superior
18 mesenteric artery.

19 Q. If you have a patent SMA and
20 a ~~patent IMA~~ and a celiac axis that
21 either has high grade stenosis or total
22 ~~occlusion~~, what do you expect to see in
23 an arteriogram?

24 A. If there is ~~collateral blood~~
25 supply to the celiac axis, then I would

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1 see most likely prominent inferior
2 pancreatic duodenal arteries arising
3 from the SMA extending into the
4 gastro-duodenal artery, up into the
5 hepatic artery and then feeding the
6 celiac axis via this route. That is
7 the most common route of collateral
8 circulation for celiac stenosis or
9 occlusion.

10 MS. ATWELL: Why don't
11 we go off for just a minute while I am
12 doing this.

13 THE VIDEOGRAPHER:
14 Videotaped deposition off record at 4:48
15 p.m.

16 (Recess taken.)

17 MR. TORGERSON:
18 Videotaped deposition back on record at
19 4:48 p.m.

20 BY MS. ATWELL:

21 Q. What are your ~~criticisms~~ of
22 Dr. ~~Blackburn~~?

23 A. I think that an incomplete
24 aortogram was performed. When
25 evaluating a patient who has aortal

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1 femoral or aortal iliac disease one must
2 look at the entire aorta starting at
3 the level of the celiac axis and going
4 inferiorly. I would say that especially
5 in a patient who has evidence of
6 significant vascular disease involving
7 the carotids and the peripheral vessels.
8 He may be subject to having vascular
9 disease in the ~~more proximal portion of~~
10 the aorta as well and one has to be
11 able to verify that and either include
12 it or exclude it.

13 When looking at the films
14 that we reviewed now, ~~when seeing a~~
15 ~~patient who has a prominent superior~~
16 ~~mesenteric artery~~, I think it's
17 ~~important to exclude -- either include~~
18 ~~or exclude the reasons why that inferior~~
19 ~~mesenteric artery is prominent.~~

20 And according to the
21 deposition that I saw on videotape and
22 reading the written deposition, the
23 second deposition which related to the
24 films that were found subsequently, ~~to~~
25 ~~attribute the inferior mesenteric artery~~

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1 prominence just to the fact that the
2 patient had iliac artery occlusion is
3 wrong.

4 I think one has to
5 exclude that the patient doesn't have
6 iliac -- doesn't have inferior
7 mesenteric iliac prominence caused by
8 vascular disease involving the two more
9 proximal visceral vessels, meaning the
10 celiac or the SMA. I think when you
11 avoid or you do not get that
12 information, that's below the standard
13 of care.

14 Q. Are you saying that without
15 discussing with the patient a wish or a
16 decision to expand the study, and
17 without a surgeon's order requesting a
18 mesenteric study, Dr. Blackburn should
19 have expanded this study on August 25
20 to include the study of the SMA and the
21 celiac axis?

22 A. I think your phrasing of the
23 question is incorrect. I think the
24 request asks for an aortal bilateral
25 femoral arteriogram. He did not provide

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1 an aortal bilateral femural arteriogram;
2 he provided part of an aortal bilateral
3 femural arteriogram.

4 But going on from your
5 question I would say this: Is that if
6 I see something on a film which
7 indicates that there may be problems
8 somewhere else and it really doesn't,
9 cause any greater damage or risk to the
10 patient, I go ahead and I do it; I
11 think that's appropriate.

12 If I saw on that shot
13 that showed the kidneys something that
14 looked like a renal tumor like a
15 carcinoma of the kidney, should I not
16 pursue that just because the doctor
17 didn't tell me to look for renal
18 cancer? That would not be good
19 medicine. I think it's good medicine
20 to do what's appropriate based on what
21 the study shows you.

22 Remember we talked before
23 about how much contrast I would have to
24 use, and I said, well, depending upon
25 whether I have all the information

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1 necessary I might have to make another
2 injection to look at a certain part of
3 a blood vessel that wasn't seen on my
4 initial series of films. I would be
5 wrong if I didn't go ahead and say do
6 another injection to make a diagnosis.
7 I have to do what's necessary to get
8 the diagnosis.

9 So the answer is yes, I
10 think it's necessary if there is
11 something which is suspicious or
12 something which indicates that something
13 else is wrong or could be wrong, I
14 think it's important for the physician
15 -- for the radiologist to get the films
16 that are necessary to include or exclude
17 the problem.

18 Q. Are you going to be offering
19 any opinions regarding the standard of
20 ~~care as to~~ Dr. De Blasio?

21 A. I don't -- Dr. De Blasio is
22 who?

23 Q. A general surgeon.

24 A. I'm not a surgeon, so I have
25 no expertise in that area.

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1 Q. Are you going to be offering
2 any opinions as to the performance of
3 medical care provided by Dr. Darwin, the
4 vascular surgeon?

5 A. I'm not a vascular surgeon,
6 I can't give you opinions what he did,
7 whether it was right or wrong.

8 MR. MARGOLIS: For the
9 purposes of the record, one of the
10 questions that I do anticipate asking
11 you at trial, Doctor, is Dr. Darwin did
12 read the arteriograms, and I imagine
13 some of the testimony that he has
14 given, you know, may lap over as to Dr.
15 Darwin's reading of the arteriograms and
16 I want to disclose that.

17 MR. LALLY: Is it going
18 to lap over into Dr. De Blasio?

19 MR. MARGOLIS: It's not my
20 depo.

21 MR. LALLY: You are
22 making representations, so --

23 MR. MARGOLIS: And I made
24 it as to Dr. Darwin.

25 MR. LALLY: Okay.

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1 BY MS. ATWELL:

2 Q. Do you work with vascular
3 surgeons?

4 A. Yes, ma'am.

5 MR. MARGOLIS: I'm sorry,
6 Cheryl, I lost --

7 BY MS. ATWELL:

8 Q. Do you work with vascular
9 surgeons?

10 MR. MARGOLIS: Oh, okay.

11 THE WITNESS: I do.

12 BY MS. ATWELL:

13 Q. Are you going to be offering
14 an opinion as to whether or not the
15 failures that you place with Dr.
16 Blackburn proximately caused the death
17 of this gentleman?

18 A. I think my role as an expert
19 is to talk about whether or not an
20 appropriate study was done and
21 interpret the films as they were there.
22 I think that the inference can be made
23 on the basis of my testimony, but I
24 can't tell you anything more than that.
25 Since I wasn't there at surgery, I can

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1 only tell you what I know from the
2 reports.

3 I think there is some --
4 there is some causal relationship, but
5 I'm -- my role as the expert is to look
6 at these films and give an
7 interpretation as to what they show and
8 was the study adequate.

9 Q. So my understanding what you
10 are telling me is that you do not
11 believe that your role is to provide
12 testimony to a reasonable medical
13 certainty as to the cause of this
14 gentleman's death, am I understanding
15 you correctly?

16 A. My role, I think, is to
17 testify to a reasonable medical
18 certainty whether or not the angiogram
19 was interpreted appropriately and
20 whether an adequate test was performed.

21 MS. ATWELL: Okay. I
22 have no other questions, thank you.

23 MR. TORGERSON: Doctor,
24 I probably have some questions. In
25 fact, I know I do.

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1 EXAMINATION OF LOUIS ADLER, M.D.
2 BY-MR.TORGERSON:

3 Q. What I am going to ask our
4 court reporter to do is to mark your
5 original Saturday, July 31st, 1999
6 report as Adler Deposition Exhibit A and
7 your follow-up Tuesday, November 9th,
8 1999 report as Adler Deposition B, and
9 Mr. Finelli's letter of July 29th, 1999
10 as Adler Deposition Exhibit C. We can
11 do that now or I suppose we ought to do
12 that now or -- I suppose we can do that
13 now. Yeah, why don't we do that now.

14 Why don't we go off the
15 record for a minute or two.

16 - - - - -

17 (Thereupon, Defendant's
18 Exhibits-AthruC were marked
19 for purposes of identification.)

20 - - - - -

21 (Discussion off record.)

22 MR. TORGERSON: We can
23 go back on the record.

24 Q. Doctor, Mr. Lally mentioned
25 your C.V. which was not produced here

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1 today, that's your resume. I take it
2 you have one and that it's up to date?

3 A. Yes, sir.

4 Q. Is it up to date through at
5 least the end of '99?

6 A. Through '99.

7 Q. Would that have -- that
8 document, that C.V. have on it all of
9 your medical affiliations, licensure,
10 certifications, publications,
11 memberships, that kind of thing?

12 A. Yes, sir.

13 Q. By memory can you tell me if
14 it's a multi-page document?

15 A. It's about 30 pages.

16 Q. And some of those 30 pages
17 contain the publications you yourself
18 have authored or have published?

19 A. In conjunction with other
20 people, yes.

21 Q. All right. Is that what by
22 and large the C.V. consists of?

23 A. Yes, sir. Primarily that
24 and then my work experience.

25 Q. For purposes of the

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1 continuation of this deposition we will
2 refer to that as Adler Deposition
3 Exhibit D. I will make a request to
4 counsel during this deposition to obtain
5 a copy and to make it available. We
6 will have it expose facto marked as
7 Exhibit D and it will be included with
8 this deposition, all right?

9 A. That's fine.

10 Q. All right, thanks.

11 - - - - -

12 (Thereupon, Defendant's
13 Exhibit-D was marked for
14 purposes of identification.)

15 - - - - -

16 BY MR. TORGERSON:

17 Q. You were earlier asked
18 regarding your certification and your
19 licensure. Are you licensed in any
20 other states besides California to
21 practice?

22 A. I was at one time licensed
23 in Illinois, but I don't think I am no
24 longer licensed in Illinois.

25 Q. That has lapsed or become

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1 inactive?

2 A. Inactive.

3 Q. Have you ever been licensed
4 in any state including those that you
5 have mentioned where your license has
6 been suspended or revoked for any
7 reason?

8 A. I have only been licensed in
9 California and Illinois, and my license
10 has never been suspended or revoked.

11 Q. Have you ever been on the
12 staff or affiliated with any hospital
13 including the ones we mentioned and the
14 others where your privileges have been
15 suspended or revoked for any reason?

16 A. My privileges have never
17 been suspended or revoked from any
18 hospital I have been attending.

19 Q. You were board certified in
20 the sub-specialty of radiology?

21 A. Yes, sir.

22 Q. And you have been practicing
23 that specialty for the past 30 years; I
24 take it since 1970?

25 A. Since 1970.

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1 Q. And you are appearing here
2 today as an expert in the field of
3 invasive arteriograms?

4 A. Vascular arteriograms.

5 Q. You earlier indicated moments
6 ago that you view your role as an
7 expert based on what you were asked to
8 review as an expert in invasive
9 radiology and not as a vascular surgeon
10 or a general surgeon; is that correct?

11 A. That's correct; I am neither
12 a vascular surgeon or general surgeon.

13 Q. Counsel has kindly indicated
14 that some of your opinions, comments and
15 views as they relate to your
16 interpretation of the x-rays, the
17 arteriograms, some of which we have
18 looked at today, may have an implication
19 on others in this case; is that your
20 understanding or were you hearing this
21 for the first time?

22 A. No, I agree.

23 Q. You initially received a
24 discreet set of arteriograms that did
25 not include the ones that you requested

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1 that show above the renals; is that so?

2 A. Well, I have never seen
3 anything above the renals. My first
4 set of images were from the pelvis in
5 the area below the renals and the films
6 of the legs -- of both legs. On the
7 basis of the x-ray report where the
8 radiologist says he visualized the
9 renals, I said there have to be more --
10 other films.

11 I was told there were no
12 other films, but subsequently I guess
13 through diligence they were able to find
14 these digital films that we just looked
15 at that show the renal arteries and the
16 aorta below that portion; those are the
17 only films that I have visualized.

18 Q. All right. Is there
19 anything pertinent to your opinions
20 regarding what should be visualized --
21 strike that question.

22 Let me for the moment
23 return to Exhibit C which is Dr.
24 Finelli's letter to you of January 29th,
25 1999. That lists all of the materials

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1 that you reviewed prior to rendering
2 your report of July 31st, 1990, Exhibit
3 A, two days later?

4 A. Yes, sir.

5 Q. And the only additional
6 things that you have reviewed since
7 that time prior to rendering your report
8 of November 9th, 1999, Exhibit B, were
9 the follow-up set of arteriograms, the
10 digital arteriograms?

11 A. Which show the renal
12 arteries, that's correct.

13 Q. And subsequent to that the
14 only additional things that you have
15 reviewed have been the second follow-up
16 deposition of Dr. Blackburn?

17 A. That's correct.

18 Q. And you have reviewed
19 nothing else?

20 A. That's correct.

21 Q. Your understanding of the
22 ~~underlying facts~~ of this case,
23 therefore, come from ~~Mr. Finelli's~~
24 ~~summarization of the facts as set forth~~
25 in his letter of -- is it July 29th,

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1 1999?

2 A. No, sir, because I told you
3 in the beginning of my deposition I was
4 also sent copies of the summary from
5 University Hospital which --

6 Q. Is that mentioned in there
7 too, in Mr. Finelli's letter, Exhibit
8 C?

9 A. It says "~~Disposition summary~~
10 of Virgil Slusher, deceased, 9/15/95
11 given at University Hospital of
12 Cleveland"; it's listed as one of the
13 items I reviewed.

14 Q. I am recalling what you
15 earlier testified to, Doctor. You said
16 you saw something at University
17 Hospital, the disposition, the coroner's
18 report --

19 A. Correct.

20 Q. -- the report of surgery --

21 A. Correct.

22 Q. -- by Dr. Darvin.

23 A. That's correct.

24 Q. The report of the 8/25/1995
25 arteriograms signed off by Dr.

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1 Blackburn.

2 A. Correct.

3 Q. Okay. In supplementing
4 those with Mr. Finelli's --

5 A. Cover letter.

6 Q. -- cover letter which
7 contain facts as he saw the case based
8 on, I take it, his review of those
9 documents and possibly other documents?

10 A. I think you have to ask Mr.
11 Finelli, not me --

12 Q. Okay.

13 A. -- how he wrote what he
14 wrote.

15 Q. Let me ask the question this
16 way: Are the facts that he set forth
17 in his letter to you all contained
18 within the documents he sent you?

19 A. I don't know. Say that
20 again, I didn't understand you.

21 Q. All right. I will be glad
22 to, and maybe it wasn't a good
23 question. I'm glad you stopped me.

24 Are the facts that he
25 delineated in his letter of July 31st,

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1 the July 29th, 1999, facts which are
2 all apparent from the materials -- the
3 medical materials which he sent you to
4 review?

5 MR. MARGOLIS: Inclusive of
6 the x-rays, Ken?

7 MR. TORGERSON:
8 Including the x-rays, not excluding
9 them.

10 THE WITNESS: I would say
11 that the ~~summary provided in Mr.~~
12 ~~Finelli's letter basically reiterates~~
13 ~~what came in the reports that he sent~~
14 ~~along with this cover letter.~~

15 BY MR. TORGERSON:

16 Q. Right.

17 A. There was nothing -- I don't
18 believe that there was anything that was
19 interpretive or added on his part
20 relative to what I saw by reading the
21 summary from University Hospital, the
22 surgeon's report, the x-ray report and
23 looking at the films.

24 Q. For instance, Doctor, you
25 have never seen Dr. Silver's, the

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1 primary care physician of Mr. --

2 MR. MARGOLIS: Slusher.

3 BY MR. TORGERSON:

4 Q. -- Slusher which sets forth
5 his examinations, physical histories and
6 complaints that predated the referral to
7 Dr. Darwin?

8 A. No, I have not.

9 Q. And you have no knowledge up
10 to this point in time as to why Mr.
11 Slusher was sent to Dr. Darwin, do you?

12 MR. MARGOLIS: I'm going
13 to object, Ken. I set forth on the
14 record what Dr. Adler's expert opinions
15 encompass; he has testified to those
16 opinions with Cheryl, and in all due
17 respect I'm not going to sit here and
18 have you ask many, many questions which
19 are clearly outside of the area of what
20 this expert is going to testify to. He
21 has told you what his testimony is
22 going to be.

23 MR. TORGERSON: Well, I
24 don't think he has told us all, and
25 although you have mentioned what you

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1 think the general parameters are --

2 MR. MARGOLIS: Let me go
3 off the record a minute and I will
4 speak with you.

5 MR. TORGERSON: Sure.

6 THE VIDEOGRAPHER:
7 Videotaped deposition off record at 5:07
8 p.m.

9 (Recess taken.)

10 MR. TORGERSON:
11 Videotaped deposition back on record at
12 5:09 p.m.

13 MR. MARGOLIS: Let the
14 record reflect that I will make this
15 stipulation and representation as it
16 pertains to Dr. Adler's testimony,
17 questions he will be asked at trial
18 pertinent to Dr. Darwin. Dr. Adler
19 will be asked about the x-rays which he
20 has testified to previously in great
21 detail in response to Ms. Atwell's
22 questioning.

23 In addition because Dr.
24 Darwin has indicated that he uses the
25 arteriograms as his road map for

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1 surgery, the testimony that Dr. Adler
2 has given about those arteriograms would
3 also apply to Dr. Darwin's
4 interpretation of them; it is for that
5 sole limited purpose that Dr. Adler's
6 testimony at trial may include Dr.
7 Darwin.

8 MR. TORGERSON: Okay.
9 Thanks very much for that statement.

10 Q. But as I was saying -- no,
11 as I was earlier -- could you take a
12 look at your letter, Doctor, of November
13 9th, 1999?

14 I have one copy here.
15 Yeah, here, let's you give you that.
16 That's Exhibit B. Well, I have got
17 mine all marked up.

18 Okay, you are looking at
19 Exhibit B, your letter of November 9th,
20 1999?

21 A. Yes, sir.

22 Q. Is that intended to
23 supplement or to replace your earlier
24 letter?

25 A. Supplement.

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1 Q. With regard to the last
2 paragraph on this two page report, or
3 actually the second to the last
4 paragraph that begins with "These
5 anatomic findings"; do you see that?

6 A. Yes, okay.

7 Q. Based upon my understanding
8 of what Mr. Margolis has just told us
9 that he is going to have you testify
10 to, you will not be testifying to any
11 of the things that are set forth in
12 that statement; is that correct?

13 Because those fall outside
14 the interpretation; those deal with
15 causative issues, is that so, or
16 hypothetical situations of what might
17 be; you are not going to testify to
18 that, are you?

19 MR. MARGOLIS: Well, he is
20 going to testify to whatever he has
21 articulated and stated as his opinion in
22 his report, so if it's in his report,
23 then, yes, I may ask him about it at
24 trial.

25 MR. TORGERSON: Well,

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1 that isn't what my understanding is of
2 what you told me that he was going to
3 do. My understanding was that he was
4 going to testify to his interpretation
5 of the arteriograms and as to what they
6 disclose or he feels they disclose but
7 nothing else as it impacts Dr. Darvin.

8 MR. MARGOLIS: I indicated
9 that he -- that is correct, as it
10 pertains to Dr. Darvin.

11 MR. TORGERSON: All
12 right. So at least with regard to this
13 paragraph we are looking at, is Dr.
14 Adler or is Dr. Adler not going to be
15 testifying as to what happened or what
16 might happen after the arteriograms were
17 reviewed?

18 MR. MARGOLIS: I think you
19 should ask him the questions so you
20 don't feel precluded. I think that
21 that paragraph that you are making
22 reference to falls within the confines
23 of what he has previously testified to
24 relative to his interpretation of the
25 angiograms, so let's not keep playing

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1 Ping-Pong. He may testify to that if I
2 ask him, so you ask him now.

3 MR. TORGERSON: Okay.
4 Well, I misunderstood what you told me
5 out in the hall and what you put on the
6 record and which --

7 MR. MARGOLIS: I think
8 what I put on the record is inclusive
9 to what he testified to, and what's in
10 the paragraph that you refer to is part
11 and parcel of what he testified to. So
12 there is no misunderstanding, Ken, you
13 ask.

14 MR. TORGERSON: Good. I
15 would be glad to.

16 Q. Now, in ~~n~~
17 arteriograms which you reviewed in
18 connection with your retention as an
19 expert by the plaintiff, do they
20 demonstrate the celiac ~~axis or its~~
21 branches, or the SMA ~~or its branches~~
22 ~~is that~~ so?

23 A. That's correct, sir.

24 Q. So ~~that~~ ~~is no~~
25 objective evidence by way of arteriogram

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1 as to what the conditions of those two
2 vessels are, the two larger vessels,
3 correct?

4 A. I can only infer that there
5 could be a problem because of the
6 abnormal appearance -- the prominent
7 appearance of the inferior mesenteric
8 artery, but since I did not see or we
9 cannot see the celiac or the SMA, I
10 can't tell you exactly what the
11 pathology is.

12 Q. All right. So that your
13 only view about what may be the
14 condition or pathology of both the SMA
15 and the celiac arteries or the axis is
16 based on inference; is that so?

17 A. ~~That's correct, sir.~~

18 Q. And that inference is based
19 on your medical inference of what you
20 see in these arteriograms, correct?

21 A. ~~It's based on my~~
22 ~~interpretation of what I see on these~~
23 ~~films.~~

24 Q. All right. You as a
25 radiologist, invasive radiologist, your

1 job is to interpret x-rays day in and
2 day out; is that so?

3 A. Yes, sir.

4 And perform procedures.

5 Q. Incident to the
6 interpretation?

7 A. Correct.

8 Q. I didn't mean to exclude
9 that.

10 Are you going to testify
11 at all with regard to the surgical
12 report prepared by Dr. Darwin following
13 his surgery as to the appropriateness or
14 inappropriateness of any procedure
15 performed or potential resulting effect
16 from any procedure performed or not
17 performed?

18 A. No, sir.

19 Q. You have not been asked, I
20 take it, to provide any opinion with
21 respect to what might have caused the
22 bowel infarct in this case; is that so?

23 Let me ask the question
24 this way: You do not know objectively
25 what caused the bowel infarct in this

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1 case?

2 MR. MARGOLIS: I'm going
3 to object; are you asking him does he
4 have an opinion within a reasonable
5 degree of medical certainty?

6 MR. TORGERSON: No, I'm
7 not. I am asking him whether he knows
8 what caused the bowel infarct in this
9 case.

10 THE WITNESS: I ~~can only~~
11 ~~make an inference as to what caused the~~
12 ~~bowel infarct since the patient didn't~~
13 ~~have a post mortem examination, if~~
14 ~~that's correct. I can only go on --~~

15 BY MR. TORGERSON:

16 Q. Would that have been a more
17 reliable basis other than an inference
18 as to what caused the bowel infarct in
19 your judgment?

20 A. I ~~think that would have~~
21 ~~added to my interpretation of what~~
22 ~~caused the bowel infarct. I do have an~~
23 ~~opinion, but do I have objective~~
24 ~~evidence other than what I saw on the~~
25 ~~films here, no.~~

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1 Q. Does your opinion as to what
2 caused the bowel infarct fall within or
3 without your medical specialty as an
4 invasive radiologist who performs
5 procedures and provides opinions as to
6 what he sees on those arteriograms?

7 A. I think it falls within the
8 realm to some degree, and the reason I
9 say that is that if I look at an
10 angiogram and it has like a certain
11 finding -- like I said before, if I saw
12 something that looked like a renal tumor
13 in this patient's arteriogram and then I
14 did a subsequent series of films to
15 prove ~~that the patient had a~~
16 ~~hypernephroma or renal tumor, I can make~~
17 ~~some inference as a somewhat educated~~
18 ~~physician that something should be done~~
19 ~~for this patient's renal tumor in~~
20 ~~addition to something that should be~~
21 ~~done for the patient's peripheral~~
22 ~~vascular disease.~~

23 ~~If I look at an~~
24 ~~arteriogram such as this patient had and~~
25 ~~I see something which indicates that~~

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1 either the test was not complete and
2 not enough information was obtained to
3 include or exclude other pathology, and
4 then you tell me that the patient died
5 from ischemic bowel disease where he
6 infarcted his gut from the ligaments of
7 Trites to the rectum, it would be
8 impossible for me not to make some
9 inference as to what was the cause of
10 it.

11 Do I know the exact
12 pathology? Well, I know that the
13 surgeons at University Hospital opened
14 this guy up and closed him, he had a
15 bowel perforation, and he had total
16 necrotic bowel from the ligament of
17 Trites to the rectum. I can add two
18 and two together. I don't have the
19 marbles in front of me, but I can make
20 an educated guess.

21 Q. We are not asking you to
22 make an educated guess, Doctor. I
23 simply asked you whether it was within
24 the realm of your normal daily
25 professional practice as an invasive

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1 radiologist to render opinions as to the
2 causation of bowel infarct when you
3 normally do invasive procedures and
4 interpret those results?

5 MR. MARGOLIS: And he
6 answered your question. Do you want
7 him to answer it again?

8 MR. TORGERSON: He did
9 give an answer, I think we have been
10 through this before.

11 Q. Is your answer to the
12 question which Mr. Margolis feels is the
13 same question I asked you previously the
14 same as you have just given?

15 A. ~~Yes~~.

16 Q. That you as a physician can
17 make an educated guess by putting two
18 and two together; is that what your
19 answer is?

20 A. As an example -- and the
21 answer is yes, but I want to clarify
22 for you so you understand.

23 Q. All right.

24 A. This week I was called to
25 see a patient who had a liver biopsy

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1 but had a horrendous drop in the
2 patient's hepatic hemoglobin and was
3 found to have a lot of blood in the
4 peritoneal cavity, so I was asked to do
5 an angiogram on that patient to see if
6 I could find the source of the
7 bleeding.

8 So I did an angiogram, I
9 put a catheter in the celiac axis and
10 found a bleeding site in the liver --
11 something that looked like a bleeding
12 site in the liver. I took a smaller
13 catheter, threaded it through the little
14 five French catheter I had in that
15 artery, and I embolized it; I put
16 something in the artery to block it, to
17 plug it up because I made the
18 interpretation that that was the source
19 of the patient's bleeding.

20 The patient's got all this
21 blood in the peritoneal cavity and had
22 a liver biopsy and I see an abnormal
23 artery. I plugged the artery up and
24 the patient stopped bleeding. Yes, I
25 make interpretations. I'm an

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1 interventional radiologist, I have to
2 make interpretations on the basis of
3 what I see on the films.

4 Sometimes it involves me
5 doing something. Sometimes it makes me
6 go to the surgeon and say, "Joe, this
7 is what I think is going on, I think
8 something else should be done," or I
9 have to do something else. I make
10 those kinds of interpretations. I do
11 that, that's part of my job.

12 Q. Well, let me ask you this,
13 then, Dr. Adler: What are the bases for
14 -- we are going to change tapes now.

15 MR. TORGERSON:
16 Videotaped deposition off record at 5:21
17 p.m. This concludes tape one.

18 (Recess taken.)

19 MR. TORGERSON:
20 Videotaped deposition back on record at
21 5:24 p.m. This is the beginning of
22 tape two.

23 MR. MARGOLIS: I think
24 when we went off a question was put to
25 you which you didn't have the

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1 opportunity to answer, and the question
2 was what was the basis for your
3 opinion, and then we went off because
4 the tape needed to be changed, so I
5 would like you to finish your answer.

6 MR. TORGERSON: Well,
7 you may want him to finish his answer,
8 but there was an incomplete question
9 there and I have decided to withdraw
10 the question.

11 MR. MARGOLIS: Read the
12 question back, please, before we went
13 off the record.

14 MR. TORGERSON: We can
15 have the question read back. I don't
16 think you are entitled to have him
17 answer any question that I have
18 withdrawn, so we will have it read
19 back.

20 MR. MARGOLIS: And he will
21 answer it and the court will decide
22 whether his answer stands or is
23 excluded.

24 (Record read.)

25 BY MR. TORGERSON:

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1 Q. Dr. Adler, could you tell me
2 what you believe is the medical or
3 scientific evidence which supports in
4 your opinion the fact that there may
5 have been or was a high grade stenosis
6 in either the SMA or the celiac axis?

7 A. The ~~inferior mesenteric~~
8 artery and its ~~marginal artery~~ were
9 prominent.

10 Q. Anything else?

11 A. And the reasons that they
12 become prominent in most cases -- I
13 mean with most cases is when this
14 vessel is acting as a source of
15 collateral blood supply to some other
16 part of the body.

17 Q. Is there any other medical
18 or scientific evidence on which you base
19 your belief as to the high grade
20 stenosis or occlusion in either the SMA
21 or celiac axis besides the prominence of
22 the IMA?

23 MR. MARGOLIS: And marginal
24 is what he said.

25 BY MR. TORGERSON:

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1 Q. And marginal, I didn't mean
2 to --

3 A. Without seeing the vessels I
4 can only say that it's a presumptive
5 diagnosis on my part. It's suspicious
6 that that is the cause.

7 Q. Is there any other medical
8 reason that you know of why the IMA
9 could be prominent without the SMA or
10 the celiac axis having high grade
11 stenosis or occlusion?

12 MR. MARGOLIS: Objection;
13 asked and answered, and pertaining to
14 this case, Ken, or in general?

15 MR. TORGERSON: It's an
16 open-ended question.

17 MR. MARGOLIS: When you
18 answer, please indicate whether you are
19 answering in general or pertinent to the
20 facts in this case and the arteriograms
21 that you reviewed.

22 THE WITNESS: ~~Pertinent to~~
23 ~~this case~~ and the films that I have
24 seen and we have looked at here today,
25 I have seen no other cause for the IMA

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1 and marginal artery being prominent.

2 BY MR. TORGERSON:

3 Q. What other medical causes in
4 general might account for a prominent
5 IMA without occlusion in the SMA or
6 celiac axis?

7 A. If there were a pelvic or
8 rectal arteriovenous malformation of a
9 large degree that you could see, meaning
10 something where you saw big feeding
11 arteries, big draining veins; ~~this~~
12 patient ~~doesn't have that~~.

13 Q. Anything else that you know
14 of which could account for a prominent
15 IMA besides the high grade preclusive
16 condition of the SMA?

17 A. ~~Two, same~~

18 MR. TORGERSON: All
19 right. I have no further questions.

20 MR. LALLY: I don't
21 think I have too much for you, Dr.
22 Adler.

23 EXAMINATION OF LOUIS ADLER, M.D.

24 BY-MR. LALLY:

25 Q. Before when you were asked

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1 if you had any opinion about Dr. De
2 Blasio, I wasn't sure if you were
3 familiar with him at all?

4 A. I'm not familiar with him.

5 Q. So at this time is it fair
6 to say that you are not prepared to
7 offer any opinions about whether he did
8 anything that would have breached his
9 duties as to standard of care?

10 A. That's correct, I have no
11 opinion.

12 MR. LALLY: I have
13 nothing further for you.

14 MS. ATWELL: Can we take
15 a second break or 30 second break?

16 MR. MARGOLIS: Sure.

17 MS. ATWELL: Can I speak
18 to you?

19 MR. MARGOLIS: Yeah.

20 THE VIDEOGRAPHER:
21 Videotaped deposition off record at 5:29
22 p.m.

23 (Recess taken.)

24 THE VIDEOGRAPHER:
25 Videotaped deposition back on record at

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1 5:31 p.m.

2 FURTHER EXAMINATION OF LOUIS ADLER, M.D.
3 BY-MS.ATWELL:

4 Q. Looking at your report of
5 November 9, 1999, the last full
6 paragraph. In that paragraph you make
7 reference to the loss of blood supply
8 could have accounted for the infarction
9 of the bowel, and I just want to
10 confirm with you, are you going to
11 testify to ~~reasonable medical~~
12 certainty that anything ~~Dr. Blackburn~~
13 did or did not do ~~proximately caused~~
14 this patient ~~to have an infarction of~~
15 the ~~bowel~~?

16 A. ~~What I would testify to, if~~
17 asked, with reasonable medical certainty
18 is ~~that failure to adequately visualize~~
19 the ~~upper portion of the abdominal aorta~~
20 and ~~the visualization of the celiac axis~~
21 and ~~superior mesenteric artery was below~~
22 the ~~standard of care~~.

23 Q. I understand that testimony.

24 A. ~~And that is in fact there~~
25 was ~~a significant stenosis of either one~~

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1 celiac or SMA and this wasn't
2 recognized, I think, yes, this would
3 have led to his infarcting his bowel.

4 Q. My understanding of your
5 testimony is that you cannot say to a
6 reasonable medical certainty that there
7 was high degree stenosis or occlusion of
8 the SMA or celiac axis; am I correct in
9 that understanding of your testimony?

10 A. What I have said in my
11 testimony is that I can only infer that
12 that is a possibility because of the
13 prominence of the IMA; however, since
14 there were no films taken of the celiac
15 or the SMA, I can only infer that; I
16 can only infer that there may -- there
17 is possibly something wrong with those
18 two vessels given the man's final
19 outcome.

20 I can't go any further
21 since he didn't visualize that, which I
22 think is the problem.

23 MR. MARGOLIS: Is that
24 opinion within reasonable medical
25 certainty?

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1 THE WITNESS: Within
2 reasonable medical certainty, correct.
3 BY MS. ATWELL:

4 Q. Your opinion within
5 reasonable medical certainty is that he
6 didn't visualize them, correct?

7 A. My opinion is that it's
8 below the standard of care given what
9 is present on these films not to have
10 visualized the proximal abdominal aorta
11 and the origins of the celiac axis and
12 the SMA; that is below the standard of
13 care.

14 MS. ATWELL: Thank you.
15 Anyone else?

16 MR. TORGERSON: Yeah,
17 let me.

18 FURTHER EXAMINATION OF LOUIS ADLER, M.D.
19 BY-MR. TORGERSON:

20 Q. With reference to the same
21 paragraph, Doctor, when you say loss of
22 this blood supply in this clinical
23 setting, what clinical setting are you
24 talking about?

25 A. The patient who, at least by

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1 inference from Mr. Finelli's note and
2 apparently from the opinion of the
3 primary care physician who was taking
4 care of him, that in addition to and
5 possibly more primary than his symptoms
6 of clotication, that the patient was
7 experiencing abdominal pain which
8 occurred after eating and weight loss,
9 and it was the clinician's suspicion
10 that the patient had ischemic bowel
11 disease.

12 Q. It was what?

13 A. The clinician's opinion that
14 the patient was suffering from lack of
15 blood supply to the gut as a cause for
16 his post perirenal pain and his weight
17 loss.

18 Q. Whose opinion was that,
19 Doctor?

20 A. The referring physician,
21 whoever that is, that is Dr. --

22 Q. Silver?

23 A. Dr. --

24 Q. Silver?

25 A. -- Silver. Dr. Silver's

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1 opinion who in evaluating this patient
2 initially felt that the patient had
3 intestinal angina or intestinal
4 ischemia; that's the clinical evidence
5 that I am going on. He had evidence of
6 abdominal pain following his meals and
7 he had weight loss, he had a negative
8 G.I. workup; other than normal upper
9 G.I., normal berry minimus supposedly.
10 Those would be normal on a patient with
11 intestinal ischemia. That is the
12 clinical evidence.

13 That ~~clinical setting;~~
14 ~~somebody with abdominal pain and weight~~
15 ~~loss and normal other studies you have~~
16 ~~to worry about.~~ And a patient who
17 already has evidence of vascular
18 disease; he has abnormal flows in his
19 legs, he has a history of carotid
20 disease, he's got vascular problems; he
21 is 30 year smoker, ~~he may have~~
22 ~~intestinal ischemia.~~

23 So that's the ~~clinical~~
24 ~~setting that I am referring to.~~ A
25 patient with that clinical setting came

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1 in with these set of pictures, I think
2 you have to make sure you have a
3 complete arteriogram.

4 MR. TORGERSON: All
5 right. I have no further questions.

6 MR. LALLY: Nothing
7 further.

8 MS. ATWELL: The original
9 you send to me because I ordered it.
10 So I want the original and mini script
11 or condensed.

12 THE WITNESS: What about
13 his signature?

14 MR. MARGOLIS: Do you want
15 to read this?

16 THE WITNESS: I would
17 like to.

18 MS. ATWELL: You send
19 his attorney a copy.

20 THE REPORTER: Is he going
21 to sign the copy then?

22 MS. ATWELL: Yes.

23 MR. TORGERSON: You can
24 send him a copy with the original
25 sign-off sheet.

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1 MR. MARGOLIS: And I would
2 like to order a copy with a word index.

3 MR. TORGERSON: Same
4 here.

5 MR. LALLY: Yeah, I
6 will order a copy also.

7 MR. TORGERSON:
8 Videotaped deposition off record at 5:38
9 p.m. This concludes tape two.

10 - - - - -
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1 CEFARATTI GROUP FILE NO. 4034
2 CASE CAPTION: PATRICIA M. FLETCHER VS.
3 GEAUGA HOSPITAL ASSOCIATION, INC.
4 DEPONENT: LOUIS ADLER, M.D.
5 DEPOSITION DATE: MAY 5, 2000
6

7 _____
(Sign Here)

8 The State of Ohio,)
9 County of Cuyahoga)SS:

10 Before me, a Notary Public in and
11 for said County and State, personally
12 appeared LOUIS ADLER, M.D., who
13 acknowledged that he/she did read
14 his/her transcript in the above-
15 captioned matter, listed any necessary
16 corrections on the accompanying errata
17 sheet, and did sign the foregoing sworn
18 statement and that the same is his/her
19 free act and deed.

20 IN TESTIMONY WHEREOF, I have
21 hereunto affixed my name and official
22 seal at _____, this _____
23 day of _____, A.D. 2000.

24 _____
25 Notary Public Commission Expires

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1 STATE OF CALIFORNIA)
2) ss
3 COUNTY OF LOS ANGELES)
4

5 I, Marie Striegler, CSR No. 6032, do
6 hereby certify:

7 That prior to being examined, the witness named
8 in the foregoing transcript was duly sworn by me at
9 the time and place therein set forth, and was taken
10 down by me in shorthand and thereafter transcribed
11 under my direction and supervision, and I hereby
12 certify that the foregoing transcript is a true and
13 correct transcript of my shorthand notes so taken.

14 I further certify that I am neither of counsel
15 for nor related to any parties to said action, nor in
16 anywise interested in the outcome of said action.

17 I declare under penalty of perjury that the
18 foregoing is true and correct.

19 Executed this 15th day of May 2000
20 at Los Angeles, California.
21
22
23
24
25

Marie Striegler

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