IN THE COURT OF COMMON PLEAS

GEAUGA COUNTY, OHIO

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

vs. Case No.

GEAUGA HOSPITAL 97PT000126
ASSOCIATION, INC.,
et al.,
Defendants.

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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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APPEARANCES:

On behalf of the Plaintiffs:

FINELLI & MARGOLIS, P.L.L., by
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730 Leader Building
526 Superior Avenue
Cleveland, Ohio 44114

On behalf of the Defendant
Dr. Blackburn:

MAZANEC, RASKIN & RYDER CO.,
L.P.A., by
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100 Franklin's Row
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On behalf of the Defendant
Dr. Darvin:

FALLON, PAISLEY & HOWLEY,
L.L.P., by
KENNETH A. TORGERSON, ESQ.
2500 Terminal Tower
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On behalf of the Defendant
Dr. De Blasio:
ULMER & BERNE, LLP, by
ROBERT J. LALLY, ESQ.
1300 East Ninth Street
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ALSO PRESENT:
ALIZABETH JAMES, Videographer

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

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

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

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

MR. TORGERSON: My name is Ken Torgerson for Dr. Howard Darvin.

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

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

THE VIDEOGRAPHER: Would you swear in the witness.

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

EXAMINATION OF LOUIS ADLER, M.D.

BY-MS.ATWELL:

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

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

Santa Monica.

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

A. Yes, I am.

Q. Have you had your deposition taken before?

A. Yes, I have.

Q. On about how many occasions?

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

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

A. I understand.

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

A. I understand.

Q. I am going to ask you to

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

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

Q. Did you receive an undergraduate degree?

A. I did not.

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

A. That's what I said, correct.

Upon finishing medical school in 1962 I was a general medical

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

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

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

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

The Cedars of Lebanon Hospital then merged with the Mount Sinai Hospital, and the new structure was built and became Cedars Sinai Medical Center, and I was part of the radiology group that maintained our practice at that hospital. Basically from about 1975 through the current -- through 1992 I was a full time -- basically full time angiographer at Cedars doing the general visceral abdominal peripheral, all forms of angiography other than cardiac angiography.

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

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

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

A. In '70.

Q. Has it ever been re-certified?

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

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

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

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

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

that.

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

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

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

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

Q. Right.

A. -- are involved with abdominal aortograms?

Q. Right.

A. I would say approximately 80 percent of that.

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

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

Q. In performing abdominal

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

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

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

With digital subtraction

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

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

A. Yes, I have.

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

A. No, they are not.

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

A. St. Johns.

Q. -- St. Johns Hospital?

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

Q. And what was your involvement?

A. I was teaching them how to do angiography.

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

A. A combination of both.

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

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

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

A. Correct.

Q. And it was just the norm as

opposed to being something unusual?

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

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

A. Yes, ma'am.

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

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

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

A. Yes, ma'am.

Q. When did you start doing

reviews of medical malpractice claims?

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

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

A. Yes, ma'am.

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

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

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

A. California, Colorado, Texas.

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

A. I don't believe so.

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

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

A. No, ma'am.

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

A. No ma'am.

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

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

Q. Have you ever been sued for medical malpractice?

A. Yes, ma'am.

Q. How often?

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

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

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

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

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

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

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

But the other cases that I have been -- the two other cases where I have been sued and come to a point where there was either a settlement or a trial, there was only one case when I was a resident where I was sued where a judgement of $20,000 was found for me for supposedly missing a fracture.

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

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

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

report of the radiologist, a copy of the surgical report from the vascular surgeon, a short note from the University Hospital in Cleveland regarding the patient's stay at University Hospital, and a copy of the coroner's report.

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

Q. Have you read any deposition transcripts?

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

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

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

Q. Dr. Vasalere? A guy in Michigan?

A. From Henry Ford Hospital?

Q. Yes.

A. Yes, ma'am.

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

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

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

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

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

A. I don't believe so.

Q. Do you have any notes that

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

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

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

A. I did; a second letter.

Q. Can I see it?

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

MR. TORGERSON:

Videotaped deposition off record at 3:33 p.m.

(Recess taken.)

MR. TORGERSON:

Videotaped deposition back on record at 3:35 p.m.

BY MS. ATWELL:

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

A. Yes, ma'am.

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

A. That's correct.

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

A. I have that.

Q. May I see it?

A. (Handing document.)

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

THE VIDEOGRAPHER:

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

(Recess taken.)

MR. TORGERSON:

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

BY MS. ATWELL:

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

A. That's correct.

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

A. Yes, ma'am.

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

A. No, ma'am.

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

A. No, ma'am.

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

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

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

A. I was not given an autopsy report.

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

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

Q. And what was that?

A. Massive necrosis of the intestinal tract from the level of the ligament of Trites to the rectum.

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

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

BY MS. ATWELL:

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

A. Yes, ma'am.

MR. LALLY: What do you

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

MR. MARGOLIS: I think I answered it relative to what Cheryl was asking. Clearly if there is any questions you want to ask him, you can.

BY MS. ATWELL:

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

A. I think my opinions relative to what I interpret on the angiograms, I think that has some indication or some relevance to what caused necrosis, but specifically I was asked to evaluate the angiographic material that was performed on this patient and that's where my testimony should be involved with.

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

MR. MARGOLIS: (Handing document.)

THE WITNESS: It was shown to me earlier today.

BY MS. ATWELL:

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

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

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

A. That's true.

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

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

Q. Well, there are different

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

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

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

A. Would you rephrase that.

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

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

certain vessels are.

Q. Do you inject the dye differently or do you require different dye contrasts if you are doing a study of the mesenteric arteries as opposed to the femural arteries?

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

Q. Straighten me out.

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

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

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

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

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

both from the A.P. and the lateral.

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

Q. And the purpose of this exam was the femural artery studies and the carotid artery studies, correct?

A. No. It says here aorta; to me that means they were looking at the aorta as well.

Q. It says aorta bilateral femural arteriogram?

A. That's correct, aorta and

bilateral femural arteriogram. You may order just an aortogram, and I would only do an aortogram. You may order in a certain situation just a left femural arteriogram, I would put a needle or catheter in the left femural artery and just shoot the left leg because the vascular surgeon or the referring doctor has said there is no indication for looking at anything else. But once you have aorta, then you have to look at the aorta.

Q. So if this requisition came to you saying aorta bilateral femural arteriogram, what would you interpret that as requesting you to look at?

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

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

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

A. If you need a lateral, right.

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

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

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

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

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

MR. MARGOLIS: You are asking in general?

MS. ATWELL: In general.

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

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

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

About a centimeter below that is the super mesenteric artery; about a half a centimeter to a centimeter below that are the two renal arteries, and then lower down in the abdominal aorta is the inferior mesenteric artery origin which is several centimeters above the aorta bifurcation.

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

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

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

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

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

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

Do you understand what I have said?

BY MS. ATWELL:

Q. Yes.

A. Great.

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

A. Yes, ma'am.

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

is a copy (handing document.)

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

A. Yes, ma'am.

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

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

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

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

than the rest, isn't it.

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

Q. Yes.

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

Q. Would either way be appropriate?

A. Either way would be appropriate.

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

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

that limits the amount of the aorta that you see.

Q. And would you agree that if the angiography is being done to do a femural artery check, to study the femural arteries, that the placement of the catheter over the renal vessels is appropriate placement?

A. No.

Q. And why is that?

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

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

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

Q. Where?

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

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

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

Q. Well, let's presume that the purpose of the study was to obtain information regarding the bilateral femural arteries. Do you think there was any harm to the patient by placing the catheter just above the renal vessels rather than just above the aortic bifurcation?

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

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

A. I agree.

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

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

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

A. No. I disagree.

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

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

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

A. No.

Q. You load that into the computer?

A. No.

Q. How is it put into the computer?

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

Q. Do you agree with Dr.

Blackburn that one of the iliac arteries was completely occluded?

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

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

A. I think that the other iliac artery was significantly stenotic, the common iliac, and then there was an occlusion of the right external iliac and common femural artery.

Q. Do you agree with Dr. Blackburn's finding that there was severe atherosclerotic occlusive disease found in his aortic bi-femural arteriogram study?

A. I think by definition the patient had severe atherosclerotic disease and showed evidence of occlusions of the left common iliac, external iliac and common femural artery, and the right external iliac and

common femural artery.

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

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

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

A. That's what it says there.

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

A. Yes, ma'am.

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

A. I have never seen the carotid arteriogram.

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

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

Q. Okay.

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

Q. Okay.

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

MR. MARGOLIS: Objection.

THE WITNESS: I don't know.

BY MS. ATWELL:

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

A. His family history.

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

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

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

Q. What is the risk of performing an aorta bi-femural arteriogram?

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

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

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

the axillary and subclavian arteries.

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

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

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

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

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

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

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

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

when doing a study on an individual?

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

BY MS. ATWELL:

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

A. Yes.

Q. Okay. Tell me both ways.

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

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

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

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

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

Q. In this patient, because he was having both a carotid arteriogram simultaneously with the femural

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

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

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

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

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

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

Q. How much contrast material would be necessary to do the combined carotids, the arch, the entire aortic study as well as the femural runoffs?

MR. MARGOLIS: With digital technology or without?

BY MS. ATWELL:

Q. Either way.

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

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

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

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

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

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

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

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

A. By the celiac axis.

Q. Okay, the celiac axis?

A. Celiac axis provides blood

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

Q. Really distal.

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

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

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

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

A. No, I disagree.

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

A. Well, I think you have to look at the colon is supplied by two blood vessels; one is the superior mesenteric artery which supplies the secum, ascending colon and most of the transverse colon; and then the distal portion of the colon, meaning from the distal transverse colon through the splenoflexure, descending colon, sigmoid colon, rectum is supplied by the inferior mesenteric artery. So the SMA supplies a half to maybe the colon and the IMA supplies the other half of the colon.

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

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

Q. And why is that?

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

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

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

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

A. No.

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

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

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

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

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

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

A. Yes, that can happen.

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

remain patent?

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

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

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

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

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

Q. And do you need more

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. I don't understand you.

Q. Okay.

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

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

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

MS. ATWELL: Let's do it now.

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

(Recess taken.)

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

BY MS. ATWELL:

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

A. Not necessarily.

Q. Well, can it be consistent with that?

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

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

MR. MARGOLIS: Objection.

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

BY MS. ATWELL:

Q. And why do you say not likely?

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

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

A. No.

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

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

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

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

Q. And what are they?

A. The lumbars which are branches off the abdominal aorta; in cases of iliac artery occlusion or in fact aortic occlusion, the anterior epigastric arteries become collaterals and enlarged that supply collateral blood flow to the iliac and femural arteries.

Q. Anything else?

A. Those are the main sources of collateral flow.

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

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

actually filling the portion of the left internal iliac artery.

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

A. Yes, ma'am.

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

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

A. I think the IMA is prominent.

Q. And what does prominent mean?

A. Larger than normal.

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

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

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

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

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

A. That's all I use.

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

(Discussion off record.)

BY MS. ATWELL:

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

A. Okay.

Q. Well, let me use it.

A. Yes, ma'am.

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

MR. MARGOLIS: If you can identify it first.

BY MS. ATWELL:

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

A. Yes, ma'am.

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

A. Yes, ma'am.

Q. And this is the aorta, correct?

A. Yes, ma'am.

Q. And what vessel is this right here?

A. It's the left renal artery.

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

A. Is this a test?

Q. Yes, this is a test.

A. It's the right renal artery.

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

A. I'm not sure.

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

MR. MARGOLIS: Objection as to possibility.

THE WITNESS: I don't believe so.

BY MS. ATWELL:

Q. Why not?

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

Q. And why do you say that?

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

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

A. Yes, ma'am.

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

A. Not necessarily.

Q. What else could you do?

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

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

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

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

A. Yes, ma'am.

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

A. Yes, ma'am.

Q. What vessel do you believe

that is?

A. That's the inferior mesenteric artery.

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

A. It's the lumbar.

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

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

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

A. By definition the marginal

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

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

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

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

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

Q. Looking at the renal that we

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

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

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

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

Q. And what explains that?

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

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

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

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

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

A. Right, the catheter -- here

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

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

A. Are right at the curve, correct.

Q. So it just comes out and drops down.

A. Correct.

Q. The fact that the celiac axis and the SMA are not shown clearly on this film doesn't mean that they aren't there and that they aren't operating correctly?

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

Q. Let's look at --

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

BY MS. ATWELL:

Q. This is another film from

Mr. Slusher from August of 1995, correct?

A. Yes, ma'am.

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

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

Q. Because it's lower?

A. (No audible response.)

Q. Yes?

A. (No audible response.)

Q. You have to say yes.

A. Yes, ma'am.

Q. And what are we seeing here?

A. We are seeing, first of all, the mislabeling of the film with this side saying "left" when it should be right, and the reason I know that is because the inferior mesenteric artery always comes off toward the left side of the aorta, comes off anterior and to the left as opposed to the anterior and to the right, without a doubt. I have

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

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

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

Q. Okay.

A. Okay?

And to continue what you are asking me, what we are seeing is the distal abdominal aorta, the right common iliac with its area of stenosis and plaqueing. More proximally, portions of the inter-iliac artery on the right side, the occlusion or lack of filling of a left common iliac artery, no external iliac or common femural on either side, and then we see a big lumbar coming off, and you can

see this little kind of torturosity of vessels right here, and then you see a portion of the right internal iliac artery filling.

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

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

A. Slightly prominent.

Q. Now, you --

A. It's prominent; prominent.

Q. You put a qualifier on there.

A. Okay, I will take it back.

Q. Why did you call that slightly prominent?

A. I don't know. I made a

mistake.

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

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

Q. Why do you call it prominent?

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

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

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

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

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

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

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

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

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

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

Q. Which is Image 6.

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

Q. Sequential.

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

blood vessel.

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

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

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

Q. Yes. Right.

A. I would expect it to be prominent.

Q. Anything else?

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

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

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

depends on the patient.

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

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

Q. Yes.

A. So I have got the celiac patent and I have got the IMA patent but the SMA is occluded.

Q. Right.

A. Either through collaterals from the celiac axis, or from the collaterals from the IMA I would see late filling of branches in the superior mesenteric artery.

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

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

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

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

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

(Recess taken.)

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

BY MS. ATWELL:

Q. What are your criticisms of Dr. Brackburn?

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

femural or aortal iliac disease one must look at the entire aorta starting at the level of the celiac axis and going inferiorly. I would say that especially in a patient who has evidence of significant vascular disease involving the carotids and the peripheral vessels. He may be subject to having vascular disease in the more proximal portion of the aorta as well and one has to be able to verify that and either include it or exclude it.

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

And according to the deposition that I saw on videotape and reading the written deposition, the second deposition which related to the films that were found subsequently, the attribute the inferior mesenteric artery

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

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

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

A. I think your phrasing of the question is incorrect. I think he requested for an aortal bilateral femoral arteriogram. He did not provide

an aortal bilateral femural arteriogram; he provided part of an aortal bilateral femural arteriogram.

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

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

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

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

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

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

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

Q. A general surgeon.

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

Q. Are you going to be offering any opinions as to the performance of medical care provided by Dr. Darvin, the vascular surgeon?

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

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

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

MR. MARGOLIS: It's not my depo.

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

MR. MARGOLIS: And I made it as to Dr. Darvin.

MR. LALLY: Okay.

BY MS. ATWELL:

Q. Do you work with vascular surgeons?

A. Yes, ma'am.

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

BY MS. ATWELL:

Q. Do you work with vascular surgeons?

MR. MARGOLIS: Oh, okay.

THE WITNESS: I do.

BY MS. ATWELL:

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

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

only tell you what I know from the reports.

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

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

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

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

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

EXAMINATION OF LOUIS ADLER, M.D.

BY-MR.TORGERSON:

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

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

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

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(Discussion off record.)

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

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

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

A. Yes, sir.

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

A. Through '99.

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

A. Yes, sir.

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

A. It's about 30 pages.

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

A. In conjunction with other people, yes.

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

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

Q. For purposes of the

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

A. That's fine.

Q. All right, thanks.

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

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BY MR. TORGERSON:

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

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

Q. That has lapsed or become

inactive?

A. Inactive.

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

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

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

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

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

A. Yes, sir.

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

A. Since 1970.

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

A. Vascular arteriograms.

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

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

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

A. No, I agree.

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

that show above the renals; is that so?

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

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

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

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

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

A. Yes, sir.

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

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

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

A. That's correct.

Q. And you have reviewed nothing else?

A. That's correct.

Q. Your understanding of the underlying facts of this case, therefore, come from Mr. Finkelstein's summarization of the facts as set forth in his letter of -- is it July 29th,

1999?

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

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

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

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

A. Correct.

Q. -- the report of surgery --

A. Correct.

Q. -- by Dr. Darvin.

A. That's correct.

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

Blackburn.

A. Correct.

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

A. Cover letter.

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

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

Q. Okay.

A. -- how he wrote what he wrote.

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

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

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

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

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

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

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

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

BY MR. TORGERSON:

Q. Right.

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

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

primary care physician of Mr. --

MR. MARGOLIS: Slusher.

BY MR. TORGERSON:

Q. -- Slusher which sets forth his examinations, physical histories and complaints that predated the referral to Dr. Darvin?

A. No, I have not.

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

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

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

think the general parameters are --

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

MR. TORGERSON: Sure.

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

(Recess taken.)

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

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

In addition because Dr. Darvin has indicated that he uses the arteriograms as his road map for

surgery, the testimony that Dr. Adler has given about those arteriograms would also apply to Dr. Darvin's interpretation of them; it is for that sole limited purpose that Dr. Adler's testimony at trial may include Dr. Darvin.

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

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

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

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

A. Yes, sir.

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

A. Supplement.

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

A. Yes, okay.

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

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

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

MR. TORGERSON: Well,

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

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

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

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

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

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

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

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

Q. Now, in n[redacted] arteriograms which you reviewed in connection with your retention as an expert by the plaintiff, do they demonstrate the celiac [redacted] branches, or the SMA [redacted] i[redacted] so?

A. That's correct, sir.

Q. So [redacted] objective evidence by way of arteriogram

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

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

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

A. That's correct, sir.

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

A. It is based on my interpretation of what I see on these films.

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

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

A. Yes, sir.

And perform procedures.

Q. Incident to the interpretation?

A. Correct.

Q. I didn't mean to exclude that.

Are you going to testify at all with regard to the surgical report prepared by Dr. Darvin following his surgery as to the appropriateness or inappropriateness of any procedure performed or potential resulting effect from any procedure performed or not performed?

A. No, sir.

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

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

case?

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

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

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

BY MR. TORGERSON:

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

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

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

A. I think it falls within the realm to some degree, and the reason I say that is that if I look at an angiogram and it has like a certain finding -- like I said before, if I saw something that looked like a renal tumor in this patient's arteriogram and then I did a subsequent series of films to prove that the patient had a hypernephroma or renal tumor, I can make some inference as a somewhat educated physician that something should be done for this patient's renal tumor in addition to something that should be done for the patient's peripheral vascular disease.

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

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

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

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

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

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

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

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

A. Yes.

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

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

Q. All right.

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

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

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

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

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

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

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

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

(Recess taken.)

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

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

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

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

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

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

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

(Record read.)

BY MR. TORGERSON:

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

A. The inferior mesenteric artery and its marginal artery were prominent.

Q. Anything else?

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

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

MR. MARGOLIS: And marginal is what he said.

BY MR. TORGERSON:

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

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

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

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

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

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

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

and marginal artery being prominent.
BY MR. TORGERSON:
Q. What other medical causes in general might account for a prominent IMA without occlusion in the SMA or celiac axis?
A. If there were a pelvic or rectal arteriovenous malformation of a large degree that you could see, meaning something where you saw big feeding arteries, big draining veins; this patient doesn't have that.
Q. Anything else that you know of which could account for a prominent IMA besides the high grade preclusive condition of the SMA?
A. [illegible]
MR. TORGERSON: All right. I have no further questions.
MR. LALLY: I don't think I have too much for you, Dr. Adler.
EXAMINATION OF LOUIS ADLER, M.D.
BY-MR.LALLY:
Q. Before when you were asked

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

A. I'm not familiar with him.

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

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

MR. LALLY: I have nothing further for you.

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

MR. MARGOLIS: Sure.

MS. ATWELL: Can I speak to you?

MR. MARGOLIS: Yeah.

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

(Recess taken.)

THE VIDEOGRAPHER: Videotaped deposition back on record at

5:31 p.m.

FURTHER EXAMINATION OF LOUIS ADLER, M.D.

BY-MS.ATWELL:

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

A. What I would testify to, if asked, with reasonable medical certainty is that failure to adequately visualize the upper portion of the abdominal aorta and the visualization of the celiac axis and superior mesenteric artery with the standard of care.

Q. I understand that testimony.

A. And that if in fact there was significant stenosis of either the

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

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

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

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

MR. MARGOLIS: Is this opinion within reasonable medical certainty?

THE WITNESS: Within reasonable medical certainty, correct.

BY MS. ATWELL:

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

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

MS. ATWELL: Thank you. Anyone else?

MR. TORGERSON: Yeah, let me.

FURTHER EXAMINATION OF LOUIS ADLER, M.D.

BY-MR.TORGERSON:

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

A. The patient who, at least by

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

Q. It was what?

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

Q. Whose opinion was that, Doctor?

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

Q. Silver?

A. Dr. --

Q. Silver?

A. -- Silver. Dr. Silver's

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

That clinical setting; somebody with abdominal pain and weight loss and normal other studies you have to work out. And a patient who already has evidence of vascular disease; he has abnormal flows in his legs, he has a history of carotid disease, he's got vascular problems; he is 30 year smoker, he may have intestinal ischemia.

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

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

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

MR. LALLY: Nothing further.

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

THE WITNESS: What about his signature?

MR. MARGOLIS: Do you want to read this?

THE WITNESS: I would like to.

MS. ATWELL: You send his attorney a copy.

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

MS. ATWELL: Yes.

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

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

MR. TORGERSON: Same here.

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

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

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CEFARATTI GROUP FILE NO. 4034

CASE CAPTION: PATRICIA M. FLETCHER VS. GEAUGA HOSPITAL ASSOCIATION, INC.

DEPONENT: LOUIS ADLER, M.D.

DEPOSITION DATE: MAY 5, 2000

_____

(Sign Here)

The State of Ohio,)

County of Cuyahoga)SS:

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

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

_____ _____

Notary Public Commission Expires

ERRATA SHEET

PAGE	LINE	CORRECTION

STATE OF CALIFORNIA)
) ss
COUNTY OF LOS ANGELES)

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

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

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

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

Executed this 15th day of May 2000 at Los Angeles, California.

Marie Striegler