THE STATE of OHIO,
: SS:
COUNTY of STARK.

IN THE COURT OF COMMON PLEAS

MARLA J. SPREADBURY, et al., :
plaintiffs,
:
vs. : Case No. 1998CV1681
1998CV0589
MERCY MEDICAL CENTER, et al.,:
defendants.

Deposition of JOHN ANASTASI, M.D., a witness herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Constance Campbell, a Notary Public within and for the State of Ohio, at the offices of Buckingham, Doolittle & Burroughs, 4518 Fulton Drive, NW, Canton, Ohio, on FRIDAY, OCTOBER 15TH, 1999, commencing at 11:15 a.m. pursuant to agreement of counsel.

APPEARANCES:

ON BEHALF OF THE PLAINTIFFS:

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ON BEHALF OF THE DEFENDANTS MARK TAWIL, M.D. and THORACIC SURGICAL ASSOCIATES, INC.:

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I N D E X

WITNESS: JOHN ANASTASI, M.D.

(NO EXHIBITS MARKED.)

(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

JOHN ANASTASI, M.D.

of lawful age, a witness herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, being first duly sworn, as hereinafter certified, was examined and testified as follows:

MISS KOLIS: Doctor, for the record as you know my name is Donna Kolis, I've been retained to represent Marla spreadbury and her husband, Mark, in a lawsuit filed against a number of physicians.

It has been indicated to me by Mr. Ockerman you have been retained by him to be an expert witness; is that a fair and accurate statement?

THE WITNESS: That's correct.

MR. GCKERMAN: So we're clear, the purpose of Dr. Anastasi's retention is the proximate cause issue.

MISS KOLIS: That was going to be my very next question. I'll ask and get it on the record.

CROSS-EXAMINATION

BY MISS KOLIS:

Q. Prior to today I had not received a written report

from you, not that there is a requirement in the case to do so. Will you state for me the purpose for which you will bo testifying at trial?

A. I was asked by Mr. Ockerman to testify regarding his client, the radiologist, as to her involvement in this lawsuit.

Q. when you say you were asked by Mr. Ockerman to testify about his radiologist and her involvement, are you going to be rendering standard of care opinions as to Dr. Cawthon's performance in evaluating the CAT scan of September 23, 1997?

A. I don't know how to answer that question. I don't know what that means.

Q. What part didn't you understand?

A. The whole thing.

MR. OCKERMAN: Let me put it this way: We're not going to ask him to say whether Dr. Cawthon deviated from the appropriate standard of care or did not meet the appropriate standard *of* care in her interpretation of the September 23rd CT scan. He's not a radiologist.

A. If that is what you were asking ---

Q. You are not going to get up and say there is nothing on the CAT scan?

A. No.

Q. Have you seen the CAT scan in this case?

A. I have.

Q. Are you going to be offering any opinion testimony as to the appropriateness of the care rendered by the cardiothoracic surgeons in this case?

A. I'm not certain that is what I was asked to come here for.

THE WITNESS: Is that correct?

MR. OCKERMAN: That's correct.

Q. I want to be certain, this is our first and only opportunity to meet with one another prior to walking into the courtroom. Generally it's scary enough as it is, I don't like to be surprised.

I want to assure myself you won't be offering an opinion as to whether or not there was a deviation on the part of Dr. Tawil who is a named defendant?

A. Correct.

Q. Your sole function will be to discuss what you believed to be in your considered medical opinion the cause of the paraplegia?

A. Correct.

Q. Let's go through the boring things that we always have to go through, your background. Not to imply that your background is boring, but --

A. That's okay.
Q. Mr. Ockerman prior to this morning submitted to me your CV, I would like to have you take a look at it, make certain it's complete.
A. The only thing that needs to be added is I'm now chairman of the department at Lee Hospital in Johnstown as well as Aitoona.
Q. That is probably an important thing. We will add that. We will go through pretty briefly.
You indicated you are the chairman of what department?
A. cardiovascular Thoracic surgery at Lee Hospital in Johnstown at UPMC at Lee Regional.
Q. what level trauma center is the Lee Hospital?
A. It is not.
Q. It is not a trauma center?
A. No.
Q. Let's go through your background so I get it clear in my brain. I guess we'll start with medical school because that is the easiest, '76 to '80. You got --
MR. OCKERMAN: You need to say yes.
A. Yes. I'm sorry.
Q. You got to reside in Winston-Salem and go to wake Forest?
A. Correct.

Q. You finished that program, commenced your residency in general surgery?

A. Yes.

Q. Did general surgery for five years?

A. Yes.

Q. Then you did an additional two years, '85 to '87 in a straight cardiothoracic program, correct?

Q. That was at Allegheny General Hospital, right?

A. Correct.

Q. Then became Board certified, looks like you took your surgery Boards in 1986, general surgery Board?

A. Correct.

Q. Took a thoracic Board in '88?

A. Correct.

Q. Passed it the first time I assume?

A. Correct.

Q. Licensed to practice only in Pennsylvania?

A. I've held licenses in New York and Ohio, currently

Q. Doctor, are you ATLS certified?

A. Yes.

Q. As of when?

A, It's probably '92, '93. I don't have that with me right now.

Q. Are you ACLS certified?

A. Wait, what was the first?

Q. AT?

A. No, I would say no to AT, yes to AC.

Q. You've not taken the Advance Trauma Life Support certification, right

A. Yes.

Q. You have taken the ACLS?

A. Yes.

Q. At present, you just told me you are now the chairperson of the Lee Hospital, are you affiliated with any other hospitals in Pennsylvania?

A. Just Altoona Hospital and Lee Hospital. with my affiliation with Lee, I'm affiliated with the University of Pittsburgh Medical Center, because the University of Pittsburgh bought Lee Hospital,

Q. You don't go to Pittsburgh --

A. I do not.

Q. You are explaining your affiliation?

A. Correct.

Q. What level trauma center is Altoona Hospital?

A. They just got approval for Level 11 trauma center. We're not currently up and running.

Q. As of yet you have not begun to participate in trauma services at the Aitoona Hospital?

A. Have not, I've done over the last 10 years thoracic trauma, we've not been a center,

Q. Tell me, Doctor, the nature of the practice that you are involved in, medical practice?

A. I'm a cardiothoracic vascular surgeon, I do open heart surgery, bypass, bowel surgery, aneurysm surgery, trauma, aortic dissection and transection, I do various kinds of vascular surgery, femoral distal bypass, carotid surgery, every blood vessel in the body, lung surgery, esophageal surgery.

Q. There are three surgeons in your group?

A. There are now four.

Q. As of when?

A. Dr. Keeley came three or four months ago I guess, I'm not too sure.

Q. Information that I might have had that there were three in your group was accurate until just recently?

A. Correct.

Q. You yourself in that 10 year period -- what is the name of your medical group?

A. cardiothoracic Vascular surgery Group, Inc. of Altoona.

Q. That's the group that you went to there in 1989?

A. '89.

Q. That has been where you practiced ever since?

A. Correct.
Q. What particular aspect of cardiovascular and/or thoracic surgery do you consider to be that to which you have devoted the largest amount of time, if any?
A. The larger percent of our practice probably is garden variety open heart surgery, bypass, valve replacements, Ross procedure, homographs. I would say that probably 70 percent of our practice is open heart surgery, 30 percent is vascular surgery. Maybe I should say 25 percent and 5 percent is all the other stuff.
Q. when you first went to cardiothoracic and Vascular Surgery Group, Inc., in Altoona you were given privileges at the hospital?
A. Correct.
Q. As part of being granted privileges there did you become on call for trauma cases?
A. Not specifically. My partner and I took call every other night, every other weekend, whoever was on call that night, if a thoracic trauma case presented we took care of it.
Q. Was there any other medical group at the Altoona Hospital providing trauma surgery services that would have dealt with the thoracic area?
A. There were general surgeons that -- when you say thoracic area, someone came in with a trauma of a

pneumothorax, needed chest tubes, general surgeons could do that, A great vessel injury, injury to the heart, that the general surgeons could not handle.

Q. Over the past 10 years, I'm going to call it 10 loosely, looks like around 10 years, how many times have you participated in the repair of a descending thoracic aorta, a traumatically disrupted one?

A. Probably six or seven.

Q. Six or seven, correct?

A. Yes, it turns out to be like one a year.

MR. TREADON: was that a ruptured transection?

MISS KOLIS: we might want to clean up our English.

A. It gets into semantics. The pathology is called a transection. The aorta tears, is held in place by pleura, adventitia. A rupture is when that loose tissue that holds it in place opens up, the patient would exsanguinate, that is a rupture.

MR. TREADON: Excuse me for interrupting.

Q. We've all had trouble knowing what to call the situation.

The situation of the transection, it's I think your testimony, to get back to where we were, in

the last 10 years you have repaired six or seven total approximately?

A. Approximately. I can't give you an exact number.

Q. If you know, it's just anecdotal, of the six or seven repairs you did, how many of your patients became paraplegic?

A. One died on the table, exsanguinated. Two were paraplegic, the others were okay,

Q. If you have a specific recollection of it, Doctor, the patient that died, did they die on the table because their hematoma ruptured and exsanguinated before you could do the repair?

A. They arrested. when we pulled them into the operating room they had arrested, bled out the chest tubes previously placed, they were gone. It was an elderly gentleman in his 80's, I did not persist.

Q. Fair enough.

You do not have any publications; is that a fair statement?

A. I have not.

Q. Never written about research or authored anything --

A. No.

Q. -- in the area that we were discussing in this lawsuit?

A. No, I'm just a clinician.
Q. shouldn't say just, I want to make certain, Sometimes people send me these, forget to send me the publications.
A. No.
MR. OCKERMAN: Not me, I send everything.
MISS KOLIS: I'm happy there is so much paper. You never know.
Q. You knew Mike Ockerman --
A. I did.
Q. -- before you were retained in this case, correct?
A. Yes.
Q. If I understand the history correctly, Mr. Ockerman was a surgical assistant at the time when you were here in Canton at Aultman for a two year period, correct?
A. Two years, two months.
Q. When were you first contacted to review this matter for Mr. Ockerman?
A. I honestly have no idea.
Q. would there be any way for you to find out when were you contacted?
A. I would have to look at the very first letter he sent me, the date of the very first letter.

Q. Do you have a correspondence file you have retained?

A. No, I usually throw out his letters.

Q. Is it because they are highly offensive you do this?

I don't have any reason. He writes me a letter, says he would like me to review a case, so I call him up, okay, send me the case, I chuck out the letter. Then the case comes, I review the case.

Q. Your representation then to me at this morning's deposition is you've not retained the correspondence that is pertinent to this case?

A. I have not retained the cover letter on the information that is pertinent to the case, correct.

Q. You don't have any recollection when you were contacted?

A. Must have been several months ago I guess.

Q. You have testified for Mr. Ockerman in one other case, is that a fair statement, Krim vers sar, I believe?

A. I testified, yes.

Q. You did that by deposition testimony?

A. They came with a videotape.

Q. Right, because you couldn't come here for trial?

A. Correct,

Q. You've also reviewed some other cases for Mr. Ockerman?

A. I think one other case.

MR. OCKERMAN: Actually more than that.

THE WITNESS: Is it?

MR. OCKERMAN: Yes.

Q. Those are the only two matters you made an appearance in?

A, I think that is correct, yes.

Q. Have you made an appearance in any other cases for any other attorney who is a member of Mike's law firm?

A. No.

Q. You have given some expert opinions in Pennsylvania?

A. I was involved in a lawsuit where I had to testify, I was an expert for one of our cardiologists in Pennsylvania,

Q. That is pretty much the extent of it?

A. I think so, that is it.

Q. Doctor, what are you charging me per hour for your testimony today?

A. charging you?

Q. Um-hum.

A. I have no idea. I didn't know I was charging you.

Q. Do you customarily --

THE WITNESS: I thought I was charging you.

MR. OCKERMAN: she will be compensating you for your time during the deposition, I will compensate you for the premeeting.

A. I do not make my living this way.

Q. I understand.

A. If you ask me did I already decide how much I was going to charge an hour for this, I did not.

Q. Well, when you decide what you would like to charge, let Mr. Ockerman know, he'll tell me, fair enough?

A. okay.

Q. I'm getting some very surprising answers this morning.

Since we're on the subject of not your opinions at the moment, you have been sued four times?

MR. OCKERMAN: objection.

Q. Is that an accurate statement?

A. No, it's not accurate.

Q. See if I can refresh your memory.

MR. OCKERMAN: Continuing objection to the lawsuit -- previous lawsuits that he's been involved in.

MISS KOLIS: You can posit that objection, the Ohio law is pretty clear expert's lawsuits are admissible. I'll send you a copy of the case so you can use it against plaintiff's witnesses in the future.

Q. what I do customarily when someone is identified as an expert, I take it upon myself to contact the county wherein they practice medicine, through the clerk of courts determine whether or not the person is involved in litigation. Not a hidden ball trick. This is how I get these things.

Do you have a recollection of Alfred V. Lass versus John Anastasi?

A. Yes, that was my only lawsuit.

Q. what was the subject matter of the lawsuit to the best of your recollection?

A. It was this was a patient that was found on echocardiogram to have a tumor in the right side of his heart. Two echos were done showing the tumor. An MRI was done not showing the tumor. The cardiologist felt the tumor was there, the patient was symptomatic.

I operated on the patient, the patient did not have a tumor. Postoperatively he developed some blood clot around the heart from the surgery because he was placed on a blood thinner. He developed low blood

pressure, took him back to the OR, cleaned that out, he went home in seven days, he was fine, He sued me for unnecessary surgery. I won that case.

Q. There is no context when I receive these.

A. That's what it was.

Q. Do you recall a case named Dorothy Beger versus John Anastasi, M.D. and Burt Fazzy, M.D.?

A. Right.

Q. Tell me what that case was about?

A. There never was a case.

Q. So they did not take your deposition?

A. No.

Q. They filed?

A. They filed the case and dropped it. They couldn't find an expert witness to support what they were saying.

Q. You were sued but not pursued, that's the easy way to state it.

A. No money paid, no settlement, nothing.

Q. Samuel Refinger versus John Anastasi?

A. Same situation, dropped before anything was ever done.

Q. Do you know what the allegation was in that case?

A. He had an arteriogram for a vascular procedure, the arteriogram the radiologist stuck him in the arm, he developed numbness or some problem with his arm. For

some reason he sued us, we never even got to him. That was also dropped. We were dropped out of that.

Q. This one has the same, Mario Fore versus John Anastasi and Dr. Fazzy; is Dr. Fazzy your partner?

A. Yes.

Q. It all of a sudden hit me why I keep seeing the same name.

A. Mr. Fore was a patient Dr. Fazzy so he put a pacemaker in, he died during the placement of the pacemaker. I went to help him resuscitate the patient. I was dropped from the lawsuit. My partner settled that case.

Q. The Settlement regarding the group was on behalf of your partner, not yourself?

A. Right. It wasn't the group, just my partner. So I apologize to you when I say when you asked me how much was I sued, I say one because the rest of this never --

Q. The rest of them didn't really move forward?

A. Right.

Q. You didn't give deposition testimony or didn't result in settlement?

A. Right.

Q. Fair enough.

As a cardiothoracic surgeon, I'm assuming that the state of Pennsylvania, as the State of

Ohio, requires you to have continuing medica? education?

A. Correct,

Q. Is it a fair assumption for me that you are current on your CME's?

A. Yes,

Q. Doctor, what periodicals do you subscribe to?

A. Annals of Thoracic Surgery, the Texas Heart Journal, Journal of Angiography, Journal of Cardiology. I don't say I read all these, I subscribe to them. I think those are the four main ones I get. Techniques in cardiovascular and Thoracic Surgery.

Q. Subsequent to the time you became Boarded in the subspecialty of thoracic surgery, you have not been involved in any teaching?

A. I taught when I was in training at Bellevue Hospital in New York for five years. Your fifth year you have to teach the interns. YOU have to teach the medical students. As chief resident you are responsible for the lecturing and teaching.

In the Altoona Hospital as the chairman of the Department I have lectured to medical students, I've lectured to family practice residents and I've lectured to nurses.

Q. There are no cardiothoracic residents --

A. There is not.

Q. -- at Altoona?
A. Right.
Q. None at Lee either?
A. Correct,
Q. Am I correct in that assumption?
A. That's correct.
Q. During your residency were you the chief resident at some point?
A. Twice.
Q. That was implied in an answer you gave, I didn't

A. At Bellevue for my fifth year and Allegheny for my last year.
Q. When you were teaching medical students and interns, what textbook did you rely on and did you regard as an authoritative cardiothoracic text?
A. The book that the residents had to use for their testing and in-service was Spencer's Thoracic Surgery Textbook.
Q. Given you had the opportunity to instruct and help teach medical students in this particular subspecialty knowing they use Spencers, do you consider Spencers to be an authoritative source of good and reliable medical information?
A. I don't consider any source as authoritative. I

didn't lecture didactically, I lectured clinically, taking the information they were learning, putting it to clinical needs and grounds.

Q. when you say that no source is authoritative, can you tell me what you mean when you say that?

A. All the literature has -- there is tons of different opinions regarding what research people have done. The textbooks then are written based on the research done and that particular author believes in. I don't consider -- I mean all of it is probably correct, but what you choose to believe is usually based on your experience, your judgment and what works for you, what doesn't in the situation.

Q. To reach your opinion in this matter as to the proximate cause of Mrs. Spreadbury's paraplegia, what materials did you review?

A. None. what didactic material?

Q. No, what material within your possession?

A. I reviewed the medical records I was sent, several depositions.

Q. Please tell me what depositions you read.

A. Dr. Packer's, Dr. Taw l

Q. Tawil?

A. Tawil. Dr. Chyrssos and I think that is it.

Q. Did you read the deposition of the general

surgeon, Dr. Telesz, does that sound familiar to you?

A. I don't think I read it.

Q. Did you read the deposition testimony of Dr. Kralik, the cardiothoracic surgeon who actually performed the surgery?

A. *Yes.*

Q. You did read Dr. Kralik?

A. *Yes.*

Q. Did you read Dr. Cawthon's testimony, the radiologist?

A. No, I did not.

Q. Did you either from Mr. Ockerman or from reading these depositions, find yourself being able to determine what the issue in the case was, or did it matter to you?

MR. OCKERMAN: objection. Go ahead.

A. what the issue was?

Q. Do you know why the lawsuit was filed?

A. I assume because she was paraplegic.

Q. Do people ordinarily file lawsuits when someone becomes paraplegic? Don't they file lawsuits when there is an allegation of negligence?

MR. OCKERMAN: objection.

MR. TREADON: objection,

Q. If you know?

A. I don't know,

Q. How much time did you spend reading the records and evaluating these depositions before you reached your conclusion in this matter?

A. Several hours.

Q. Did you submit a bill to Mr. Ockerman for your time involved?

A. No, not yet.

MR. OCKERMAN: He will.

Q. So there is no document at your office that reflects the number of hours you spent on this case?

A. No.

Q. Did you ask to see the CAT scan?

A. I didn't ask to see it, Mr. Ockerman brought it to me, that and the arteriogram.

Q. When approximately did you see the CAT scan and arteriogram?

A. When?

Q. Um-hum.

A. I don't remember.

Q. Was it in the same general time frame of when you got records?

A. Got the records first, came with the studies, maybe a few weeks, a month later.

Q. Dr. Anastasi, based on your training and Board

certification in cardiothoracic surgery, are you capable of reading thoracic CAT scans?

A. Capable of reading it and typing it out, printing a report?

Q. No, you wouldn't do that.

A. Right.

Q. As part of your --

A. I look at them.

Q. Why do you look at them?

A. Most of the time I look at them for academic interest, to learn.

Q. My question is: Do you, based upon your training and experience, have the ability to interpret findings on a thoracic CAT scan that would sufficiently enable you to determine that there is some evidence *of* transection in a descending aorta?

A. I would not make that based on my reading, no. If somebody showed it to me, I could say oh, yeah. I sometimes even find it, but I wouldn't base a patient's treatment on my interpretation alone, no.

Q. Whose interpretation would you be looking for?

A. A Board certified radiologist.

Q. We will probably come back to that area. At this moment can you please tell me with as much specificity

trial of this lawsuit?

A. Regarding?

A, I guess it depends on what the question is. I'm not trying to be evasive with you, I'm not sure I know how to answer the general question,

Q. If I understand this correctly through Mr. Ockerman you've been retained solely for the purpose to render your considered opinion as to the cause of the paraplegia in this case?

A. Correct.

Q. Why don't you tell me what that opinion is?

A. The cause of the paraplegia is whenever you take any patient to the operating room with a transected aorta or descending aorta problem, you clamp the aorta distal to the left subclavian or proximal to the left subclavian, you cut off the blood supply to the critical intercostal vessels that feed the spinal cord, that is he reason for the paraplegia in every case.

MR. TREADON: Can you read that back?

(Answer read.)

Q. Let's say in this patient, do you have an opinion

based upon your experience and/or the literature as to what the approximate percentage risk is that any given person will become a paraplegic as a result of this repair alone?

A. when I do these operations I tell my patients, I tell the families they probably have anywhere between 5 and 20 percent of being paraplegic after the surgery.

Q. Let me ask you why it is you have such a vast range on percentage, 5 to 20?

A. Because that is what the literature says.

Q. You would agree with me there are -- I'm going to use the word authoritative -- sources published in different textbooks that have the risk as low as 5 percent, as high as 20?

A. (Indicating affirmatively.)

MR. OCKERMAN: You need to say yes.

A. Yes, I'm sorry.

Q. Are you going to be presenting any specific study to support your opinion to the jury?

A. I had not planned on it, no

Q. You are going to testify based upon your experience and your review of the literature this would be the approximate range?

A. Correct.

Q. what, Doctor, do you believe that the literature

and/or teaching experiences *has* determined to be the maximum outside length of safe tine to cross clamp to reduce the risk that paraplegia would occur?

A. I don't think there is any maximum outside time because I have had patients clamped an hour that have walked out of the hospital. I have had patients clamped 22 minutes that have been paraplegic.

The literature, when you go to the major aorta symposium, said you need to do this in under 30 minutes or you are going to have paraplegia. Yes, your incidence will be lower of paraplegia under 30 minutes, doesn't exclude it. Doesn't say if you are cross clamped an hour you are definitely going to be paraplegic.

Q. You agree with me the general thinking of the symposium of cardiothoracic surgeons is to keep the surgery under 30 minutes; would you agree with that?

MR. OCKERMAN: objection.

A. I would agree that the general feeling is that you better your chances of not being paraplegic if you are under 30 minutes.

Q. would you prefer, Doctor, to do this repair as a physician prior to the time that the transection ruptures or doesn't it matter to you?

A. See again this gets back to semantics. If the

doing the repair because the patient will be dead.

Q. In your review of the medical records, what do you believe caused Mrs. Spreadbury's hypotensive episode on the morning of September 24th?

A. In the OR or before the OR?

Q. Before.

First of all, are you aware of the fact because you read the records she had a hypotensive episode about 9:10 a.m. on the 24th?

A. Yes.

Q. Do you happen to remember what the pressure was?

A. 38 over 20.

Q. Not very good, is that a fair way to characterize it?

A. Correct.

Q. Do you know how much longer it was from 9:10 when she became hypotensive until surgery commenced?

A. They cross clamped the aorta at 11:30, they were in the OR something like 10:10 or 10:20, something like that. I would have to look at the record.

Q. Why don't you go ahead and take a look at that, I want to ask you a question about this.

A. Look likes they came in the OR 10:45.

MR. TREADON: What are you looking

at, Doctor?

Q. identify it for us.

A. Anesthetic record.

Q. So she became hypotensive I think we can agree at 9:10, it was an hour and 35 minutes until they were able to get her ready for surgery?

A. I think she went -- after she got hypotensive she went to have an arteriogram, from the arteriogram she went over to the operating room.

Q. From your review of the record from the time period of 9:10 to 10:45 would you say that she remained hypotensive?

A. No, she came into the operating room with a blood pressure of almost 100.

Q. That was by use of pressors; is that r g t

A. Volume and Dopamine from what I can see here.

Q. Can you tell from the records that were provided to you how much difficulty, if any, was encountered in getting the pressure up?

A. It really doesn't go into that. They started Dopamine, they gave her fluid and the blood pressure came up enough to get her to the arteriogram.

Q. what caused the episode to occur at 9:10?

A. She probably -- a couple of things. Her fluid status might have been low for her. She might have had

an expansion of her hematoma that was contained, so she probably lost some blood back into this hematoma, pseudo aneurysm, probably dropped her blood volume from that. There was nowhere I saw in any of the records that her chest tubes filled with blood, she exsanguinated, that would be a rupture. Expansion of the pseudo aneurysm is a different animal.

Q. The pseudo aneurysm was expanding, which would be the probable cause of the hypotension to occur at that time?

A. I would think so.

Q. Do you have an opinion as to whether or not that set of events as you see them occurring would have contributed to ischemia?

A. No.

Q. You don't think it would?

A. No, because the aorta is still intact.

MR. TREADON: I'm sorry?

A. The aorta is still intact at that time, blood is still getting to the spinal cord. Many patients come in hypotensive, no blood pressure for 40, 50 minutes while pumping on the chest, yet they are not paralyzed. It's a different animal.

Q. Based on the record you believe that the contained hematoma ruptured at the time of surgery?

A. That is what the surgeon says in his record, yes.
Q. Did that --
A. Again, it has no indication in the record -- they note that the blood pressure drops, here they have the blood pressure of 90, then they say they put her left side up, blood pressure suddenly dropped to 40. You have the patient who is losing blood into a pseudo aneurysm, who maybe their hematocrit is low, blood volume is low, giving fluid to, in a completely lying flat position they are maintaining a blood pressure. You lift them up, shift all the fluid out in a different direction, that is usually why their blood pressure drops. You can take a normal patient, put them in a different --
Q. It's like postural hypotension?
A. Yes. Does not say the blood pressure dropped to 30, the chest tubes filled. That is a free rupture. In my patient that died in the operating room, he had almost 3 liters of blood in his chest tube, that is a free rupture. This I believe was here because they got in, they clamped her, they don't give another blood pressure until the clamp I don't think.
Q. Until after the surgery?
A. No, until after the clamp they have.
Q. Are you looking at the anesthesia chart?

A. Yes. I really don't know. I can't tell you that,
Q. Do you agree or do you believe the fact that she was at the point where her hematoma ruptured complicated and lengthened the surgery?
A. Lengthened which part of the surgery?
Q. Lengthened the repair?
A. No.
Q. You don't?
A. No. If anything, the hypotension that she had speeded up at least the first part of the operation because you don't spend a lot of time prepping and draping, doing everything perfect. You get the chest open as quick as you can to get the clamp on the aorta. The 25 minutes you would have taken to open the chest you now dropped down to 5 minutes, you get in there and clamp the aorta.
Q. I understand your answer, that is because I asked a bad question.

Do you believe that the rupture of the hematoma lengthened the time that --

A. I don't know that it rup The surgeon said it ruptured, I wasn't there, I see nothing in the no to indicate there was blood everywhere so.
Q. would it be your opinion at trial that the surgeon was in error when he reported a rupture?

A. I'm not saying it was an error, that's what he felt, he was there, I wasn't.

Q. Assuming the surgeon that was there, did the surgery, was correct, there is a rupture, would that have increased the time she had to be cross clamped is my question, in order to deal with other issues going on in the chest?

A. No.

Q. Doctor, when you performed the surgery, as you indicated you've done it six or seven times in 10 years, correct?

A. Um-hum.

Q. what method do you use to repair a transected descending thoracic aorta?

A. I've done it three different ways. I've done it clamp, clamp, sew. I've done it left arterial/femoral areery bypass, i've done ie systemic hyporhermia, circulatory arrest.

MR. TREADON: Say those again.

A. Clamp, clamp, sew. Left atrial to femoral artery bypass, the purpose of doing that is keep the blood pressure higher in the lower extremity to try to protect the spinal cord.

The third technique is systemic hypcthermia, circulatory arrest. You put the patient on

femoral artery, venous bypass, take the temperature down to 14 degrees, you drain all the blood out of the body, the cold temperature not only prctects the brain but protects the spinal cord while you are doing the repair.

Q. Since you used three approaches, has this been a progressive preference on your part or random? In other words, I guess what I'm asking is when you started out did you do clamp, clamp, sew, what dictates what method you use?

A. The clinical situation of the patient most of the time.

Q. what clinical situation would you do a clamp, clamp, sew?

A. If the patient had previous bypass surgery, I couldn't get to the left atrium very easily. If the patient had peripheral vascular disease, I can't get to the femoral artery very well, I'll do it. A lot of different reasons,

If I look at the situation, I think I can clamp, clamp and sew it in under 30 minutes, I'll do it that way. It just depends.

Q. So if I heard what you said correctly, let me try to characterize it to make certain that we will be on the same page, your use of clamp, clamp, sew being dictated by the clinical situation is in all likelihood

going to occur because these other methods of what I call spinal cord sparing --

A. Right.

Q. -- are not possible due to prior surgery or a person's vessel status?

A. Right, or some other issue.

Q. Can I then apply or interpret that you would prefer to use a bypass method?

A. I prefer to use it, yes.

Q. Is that because the literature demonstrates that the ability to do that does carry with it a greater potentiai to alleviate paraplegia?

A. No, it doesn't show that.

Q. You think it doesn't show that?

A. Doesn't show that. It shows paraplegia with every technique I described. Makes me feel a little more comfortable if I do a patient and they have paraplegia, I can say I did everything I know how to do to prevent it.

Q. In determining that you were going to offer testimony in this case, reaching your opinion, did you review the recent literature?

A. I did not.

MISS KOLIS: I'm just asking if he did a literature search.

MR. OCKERMAN: Objection to your question.

A. I keep up with the literature on a monthly basis, did I get back on the computer --

Q. That's precisely what I was asking.

A. No, I did not do that.

Q. Do you intend to do a literature search prior to giving testimony at trial?

A. Probably not.

Q. So you do not believe that the hypotensive episode that began at 9:10 and continued with some variation of hypotension through the time Mrs. Spreadbury came up for the surgery contributed to her paraplegia?

A. I do not.

Q. Do you intend to, even though you are not going to apparently be asked about the standard of care of Dr. Tawil, to educate the jury as to how the surgery was done; is that something you are planning on doing, do you know?

A. I guess it depends on if you ask me something about how you do the operation. I don't plan on volunteering anything.

Q. I'm sure you don't.

MR. TREADON: And that would be prudent.

MR. OCKERMAN: Off the record.

(Discussion had off the record.)

Q. Doctor, do you have an opinion as to why -- do you have an opinion as to why it was unknown to the physicians involved in this case that Mrs. Spreadbury had a transection in her descending thoracic aorta prior to the time of surgery?

A. They knew it after the arteriogram, is that what you mean?

Q. In other words, my question is: when a person comes in with chest trauma, isn't the first order of business to determine there is not an injury to the great vessels?

A. Any patient with chest trauma?

Q. A patient after a chest trauma of the nature and extent Mrs. Spreadbury had, a decelerating chest cru ?

A. You have a high index of suspicion.

Q. Sure. Do you agree with me that it is important with a high index of suspicion to follow up diagnostically because there aren't that many pathomnemonic findings that make you think that the person had that injury?

A. Absolutely.

Q. You've looked at the CAT scan?
A. Um-hum.
Q. Did you see anything on the CAT scan?
A. I did not.
Q. Then let me ask this question --
MR. OCKERMAN: Let me say this, when I pointed him to it specifically.
Q. I think he's candidly saying you looked at it, you didn't see anything?
A. No.
Q. Do you agree with me CAT scans because they are non-invasive are a good preliminary screening tool to determine whether or not there is a transection?
A. They can be used both as diagnostic, as well as screening.
Q. If you have a screening exam which is read as negative, you have this constellation of severe chest crush, do you agree with me that the cardiothoracic literature indicates you should then proceed to angiography so you can assure that injury does not exist?
A. I think it largely depends on the individual clinician, his judgment matching what he is seeing on the CAT scan, what he is seeing in the patient, finally making a decision of his comfort level as to whether or

not he fully explained what he is seeing. If he feels comfortable with what the radiologist is telling him, what he sees on the CAT scan himself, matches it up to his patient, then he's done. If he doesn't then the burden of proof is on him to prove yes or no, to explain what he's got.

Q. would a mediastinal hematoma on the CAT scan be enough for you as a cardiothoracic surgeon to say we better get an arteriogram?

A. It would depend upon what my patient looked like, how certain I feel the radiologist was about the report.

Q. when you say depends on what the patient looks like, what are you referring to?

A. If the patient is persistently hypotensive, persistent drop in hematocrit, progressively enlarging chest x-ray, mediastinal shadow on chest x-ray, that might be a little bit more uncomfortable. I might want to proceed to arteriogram.

Q. Did you see the chest x-ray in this case?

A. I think I just saw one.

Q. Did you see a widened mediastinum?

A. There was a widened superior mediastinum on the x-ray, yes.

Q. Do you agree or disagree that the wide mediastinum in a person with a crush injury to the chest such as

Mrs. spreadbury had indicates highly there is probably a transection?

A. I don't think it indicates probably. I think it should highlight you to think that that might be going on. You should do a test to determine whether or not that is going on.

Q. since going into practice you've already indicated you subscribe to periodicals and journals that you probably keep up with to some degree?

A. Yes.

Q. Are you aware of what the consensus of literature reports to be -- how do we see a CAT scan's reliability in determining or showing that there is actually something going on in the descending aorta?

MR. OCKERMAN: Are you talking about percentage?

Q. Yes, if you know.

A. Do I know the actual number of the correct sensitivity?

Q. Right.

A. No, I would be lying, I don't know the exact number. I know there are false positives and false negatives on CAT scan, I don't know the exact number. I'm sure that would differ with every study being done

Q. In the cases, the six to seven cases that you were

involved in, did you make your diagnosis by CAT scan?

A. couple of them I did.

Q. The other couple were made by?

A. Arteriogram.

Q. The situation where the diagnosis was made by -- first of all let me back that up, did you order the arteriograms yourself in those cases, was that your decision as the surgeon to make?

A. Yes.

Q. You don't wait for the radiologist to tell you?

A. They never document it, they look at the pictures. We are clinicians.

Q. The situation where you said a couple, I think a couple is two, might be more, you used a CAT scan to make a diagnosis, do you know why you used a CAT scan in those instances?

A. They called me, told me there was a transected aorta.

Q. So someone else, in other words somebody else already ordered the CAT scan before you got --

A. The patient came into the emergency room, they had a wide mediastinum, they ordered the CAT scan. The next call I got was from the emergency room doctor saying this lady is down here, she has a transected aorta on CAT scan, the next thing I say is fine, I'll call in the

team, send her to the OR. That is how we handle that.

MISS KOLIS: I'm going to step out in the hall for one minute with Melissa. I might not have anymore questions.

(Recess had.)

MISS KOLIS: No further questions.

MR. OCKERMAN: You have the right to review your testimony or waive. I suggest you review the transcript.

Can he have 30 days?

MISS KOLIS: Yes, if you can promise me you will read it within 30 days, I'll be more than glad to waive.

(Deposition concluded; signature not waived.)

ERRATA SHEET

NOTATION	PAGE/LINE
Valve Surgery not Saved	10/6
Cardiovascular + Thoracic Surgery of Alton Inc	40/27
DR. BUST FAZI	19/7
DR. FAZI	20/4
"never decided it"	43/11

I have read the foregoing transcript and the same is true and accurate.

JOHN ANASTASI, M.D.

The State of Ohio,

County of Cuyahoga. CERTIFICATE:

I, constance Campbell, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, JOHN ANASTASI, M.D. was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript *of* the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney *of* either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 18th day of October, 1999.

Constance Campbell, Stenographic Reporter,
Notary Public/State of Ohio.
Commission expiration: January 14, 2003.

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4-436: Marla J. Spreadbury

Deposition of
John Anastasi, M.D.
Defendant's Proximate Cause Expert

October 15,1999

Exhibits: None

PAGE / LINE

4 / 16 MR. OCKERMAN: The purpose of retaining Anastasi in the proximate cause issue

5 / 4-6 I was asked by Mike to testify regarding his client, the radiologist, as to her involvement in this lawsuit

5 / 12 Didn't understand the question asking him if he was testifying about Cawthon's involvement and if he was going to rendering standard of care opinions regarding Cawthon's evaluation of the 9/23 CT

5 / 25 He is not going to testify that there is nothing on the CT scan

6 / 2 Has seen the CT scan

6 / 6 He is not certain that he was asked to come and render opinions as to the appropriateness of the care rendered by the cardiothoracic surgeon in this case

6 / 18 Will not be offering any opinions regarding Dr. Tawil and whether or not Tawil deviated from the standard of care

6 / 22 His sole function is to render his medical opinion as to the cause of the paraplegia

REVIEW OF ANASTASI'S BACKGROUND

7 / 5 The only addition to his CV is that he is no the chairman of the dept at Lee Hospital in Johnstown as well as Altoona

7 / 12 He is chairman of the Cardiovascular Thoracic Surgery Dept at Lee Hosp in Johnstown, at UPMC at Lee Regional

7 / 15 Lee Hospital is not a trauma center

7 / 25 He resided at Winston-Salem and Wake Forest from '76 to '80

8 / 3 He finished that program and began his residency in general surgery

8 / 5 He did general surgery residency for 5 years

8 / 8 He did his cardiothoracic program for 2 years - '85 to '87

8 / 10 At Alleghany General Hospital

8 / 13 He then became board certified by taking the general surgery boards in 1986

8 / 15 He took the thoracic board in 1988

8 / 17 And passed it

8 / 19 He's held licenses in New York and Ohio, and currently the PA license is the only active one

~~8 / 22 He is ATLS certified~~

8 / 24 Probably since '92 or '93

9 / 4 He's NOT ATLS certified – he's ACLS certified

9 / 7 He has not taken Advanced Trauma Life Support certification

9 / 9 He has taken the ACLS

9 / 13 He is only affiliated with Altoona and Lee Hospitals; through Lee, he also affiliated with the Univ of Pittsburgh Medical Center because the Univ bought Lee Hospital

9 / 18 He does not go to Pittsburgh

9 / 22 Altoona Hospital just got approval to be a Level II trauma center; but they are not currently up and running

10 / 1 Has not participated in trauma services at Altoona, but has done thoracic trauma over the last 10 years without being a center

10 15-10 He is a cardiothoracic vascular surgeon; he does open heart surgery, bypass, bowel, aneurysm, trauma aortic dissection and transection; he also does various kinds of vascular surgery, femoral distal bypass, carotid surgery, every blood vessel in the body, lung and esophageal surgery

10 / 12 There are 4 surgeons in his group

10 / 14 Dr. Keeley came about 3 or 4 months ago; he's not sure

10 / 18 Until recently, there were only 3 in the group

10 21 The name of the group is Cardio Thoracic Vascular Surgery Group, Inc. of Altoona

10124	He joined the group in 1989
1115-10	70% of the practice is open heart surgery, 30% is vascular surgery; about 25% and 5% is all the other stuff – ie bypass, valve replacement, Ross procedure, homographs
11/14	When he first joined the group, he was given privileges at Altoona hospital
11117	He and his partner took call every other night, every other weekend – whoever was on call that night; if a thoracic trauma case presented, they took care of it
11/24-12/3	There were general surgeons; when someone came in with trauma of the pneumothorax, needed chest tubes, the G/Ss could handle it; if it was a great vessel injury, the G/Ss couldn't handle it
1218	Over approximately last 10 years, he has participated in at least 6 or 7 repairs of a descending thoracic aorta
12115	*….the pathology is called a transection. The aorta tears, is held in place by pleura, adventitia. A rupture is when that loose tissue that holds it in place opens up, the patient would exsanguinate, that is a rupture.*
13/7	One of his transections died; 2 became paraplegic; the others were **ok**
13/13	The patient who died had arrested when pulled into the operating room and had bled out the chest tubes previously placed; the man was in his 80s
13120	He does not have any publications
13/23	Has never written about research or authored anything
1411	*I'mjust a clinician*
14113	Knew Mike before he was retained in this case
14/18	Mike was a surgical assistant at the time Anastasi was in Canton at Aultman Hosp for a 2-year period
14/21	Cannot remember when Mike first contacted him to review this matter
14/24	He would have to look at the very first letter Mike sent him to know when he was first contacted.
15/3	He does not keep a correspondence file; he usually throws the letters out
15/6-9	After he responds to the letter, he throws it out and then the case comes in for review
15113	He has not retained the cover letter from Mike that has pertinent information to this case

15 1 17	Guesses he was contacted several months ago
15 / 21	Testified for Mike in a case entitled *Krim* ***vs.*** *Assar*
15 / 23	Gave a videotaped deposition
16 1 3	Has reviewed one other case for Mike
16 1 4	MR. OCKERMAN: Actually more than that
16 / 10	However, those are the only 2 he made appearances in
16 1 13	Has never made appearances for other attorneys at Buckingham, Doolittle
16 / 16	Was involved in a lawsuit in PA where he testified on behalf of one of his cardiologist as an expert
16 / 25	Has no idea what he's charging for this deposition; he didn't know he was charging
17 / 7	States he doesn't make a living by giving deposition
17 / 21	Denies he's been sued 4 times
17 / 23	Mr. Ockerman initiates a continuing objection regarding previous lawsuits
18 1 14	Claims the *Lass* ***vs.*** *Anastasi* case was his only lawsuit
18 / 17-21	The case was about a patient who was found to have a tumor via echocardiogram on the right side of his heart; 2 echos were done showing the tumor; an MRI didn't show the tumor; the cardiologist felt the tumor was there; the patient was symptomatic;
18 / 21-25	Anastasi operated on the patient and the patient did not have a tumor; post-op, the patient developed some blood clot around the heart fi-om the surgery because he was placed on blood thinner
19 / 1-3	The patient developed low BP, Anastasi took him back into the OR, cleaned it out; The patient went home in 7 days and sued Anastasi for unnecessary surgery; Anastasi won the case
19 / 8	Does recall a case entitled *Beger vs. Anastasi & Fuzzy MD*
19 / 10	Claims it was never a case
19 / 12	He never gave a deposition
19 1 14	The plaintiff couldn't find an expert to support the case
19 / 20	In regards to *Refinger vs. Anastasi,* claims the case was dropped before anything was done

19/23-20/2 The case was about Refinger who had an arteriogram for a vascular procedure; the arteriogram the radiologist stuck him in the arm, he developed numbness or some problem with his arm; for some reason he sued and they never got to him. That was also dropped – we were dropped out of that

2015 Remembers *Fore vs. Anastasi and Fuzzy;* Fazzy is his partner

20 18-12 Fazzy was the surgeon who had put a pacemaker in Mr. Fore who died during the placement; Anastasi tried to help resuscitate the patient; Anastasi was dropped from the lawsuit; Fazzy settled the case

20 / 15 That case was not the group – just the partner; apologizes

20 122 He didn't give a deposition nor did it result in settlement

21 / 2 PA does require CME

21 / 5 Claims he is current on his CMEs

21 17-11 The periodicals Anastasi subscribes to are the Annals of Thoracic Surgery, the Texas Heart Journal, Journal of Angiography, Journal of Cardiology as well as Techniques in Cardiovascular and Thoracic Surgery; doesn't claim to read all of them but he does subscribe to them

21 115-19 He taught at Bellevue Hospital in New York for 5 years while he was in training; the fifth year required the teaching of interns and medical students; as chief resident, you are responsible for the lecturing and teaching

21 / 20-23 As chairman of the dept at Altoona, he has lectured to medical students, family practice residents and nurses

21 / 25 There are not any cardiothoracic residents (at Altoona)

2214 Nor at Lee

2219 He was chief twice during his residency

22 / 12 He was chief at Bellevue for his 5th year; and Alleghany for his last year

22 / 17 The books the residents had to use for their testing and in-service was *Spencer's Thoracic Surgery Textbook*

22 / 25 Doesn't consider any source as authoritative

23 / 1-3 He didn't lecture didactically; he lectured clinically

23 16-13	In regards to considering that no sources are authoritative, he feels there are a lot of different opinions regarding what research people of done; he chooses to believe it's usually based on one's experience, judgment and what works and what doesn't in the situation
23 / 19	In regards to this case, he reviewed the medical records he was sent and several depositions when arriving to his proximate cause opinion as to Mrs. Spreadbury's paraplegia
23 122	He reviewed the depositions of Packer and Tawil
23 / 24	Reviewed Dr. Chryssos' deposition
2412	Doesn't think he read Telesz's deposition
2416	Did read Kralik's deposition
24 / 11	Did not read Cawthon's deposition testimony
24 / 18	Assumes the lawsuit was filed because Marla is paraplegic
25 / 1	Doesn't know that people file lawsuit when there is allegation of negligence
25 / 5	Spent several hours reviewing the materials to reach his conclusion in this case
25 / 8	Has not billed Mike yet
25 / 12	Has not documented his time spent reviewing this case
25 / 14	He did not ask to see the CT scans although Mike brought it to him along with the arteriogram
25 / 20	Doesn't remember when he saw the diagnostic studies
25 / 23	*"Got the records first, came with the studies, maybe a few weeks, a month later."*
2613	In regards to being capable of reading thoracic CT scans, he's capable of reading it, typing it out, and printing a report
2618	He does look at them
261 10	Looks at them out of academic interest and to learn
26 / 17-20	Sometimes he could find evidence of a transection in a descending aorta, but sometimes would have to show it to him and he wouldn't base a patient's treatment on his interpretation alone
26 122	He would be looking for the interpretation of a board certified radiologist

27 / 13-19 His opinion as to the cause of the paraplegia is: *...whenever you take any patient to the operating room with a transected aorta or descending aorta problem, you clamp the aorta distal to the left subclavian or proximal to the left subclavian, you cut off the blood supply to the critical intercostal vessels that feed the spinal cord, that is the reason for the paraplegia in every case.*

28 15-7 *....I tell my patients, I tell the families they probably have anywhere between 5% & 20% of being paraplegic after the surgery.*

28 / 10 *Because that's what the literature says.*

28 / 17 Agrees that there are authoritative sources where the risk of paraplegia is listed as low as 5% and as high as 20%

28 120 Had not planned on presenting any specific study to support that opinion

28 / 24 Will be testifying to that based on his experience and his review of the literature as being the approximate range

29 / 4-7 Doesn't believe there is a maximum outside time because he claims to have had patients clamped an hour who have walked out of the hospital and patients clamped 22 minutes who have became paraplegic

29 18-14 Agrees the major aorta symposium said you need to do this in under 30 minutes or you'll have paraplegia and yes your incidence is lower if under 30 minutes; but it doesn't exclude it. It all doesn't say that if your cross-clamped an hour, you're definitely going to be paraplegic.

29 / 19 Agrees the general feeling of the major aorta symposium is that the chances of not being paraplegic are better if it's under 30 minutes

29/25-30/2 ***If the transection ruptures, you don't have to worry about doing the repair because the patient will be dead***

30111 Says he is aware that Marla had a hypotensive episode about 9:10 am on 9124

30 / 13 Her pressure was 38/20

30 / 16 Agrees that's not very good

30 / 19 They didn't cross-clamp the aorta until 11:30 [am]; they were in the OR at about 10:10 or 10:20

30 / 24 Looks like they came into the OR at 10:45 [am]

31 / 3 He's looking at the anesthetic record

31 / 7 After becoming hypotensive, she went to have an arteriogram and from there she went to the OR

31 113 Does not agree she remained hypotensive that whole entire time as she came to the OR with BP of almost 100

31 116 Only because they used volume and dopamine from he can see

31 / 20 The record doesn't really say how much difficulty it was to get her BP up; she was given dopamine and fluid; the BP came up enough to get her to the arteriogram

31/24-32/7 His opinion as to why the hypotensive episode occurred at 9:10 is that *her fluid status might have been low for her; she might have had an expansion of her hematoma that was contained, so she probably lost some blood back into this hematoma; pseudoaneurysm, probably dropped her blood volume from that; there was nowhere I saw in any of the records that her chest tubes filled with blood, she exsanguinated, that would be a rupture. Expansion of the pseudoaneurysm is a different animal.*

32 / 11 The pseudoaneurysm expanding could have been the probable cause of the hypotension to have occurred at 9:10

32 / 15 It is no not his opinion that that set of events contributed to the ischemia

32 / 17 It didn't contribute because the aorta is still intact

32 / 19-23 *It is his opinion that the aorta is still intact at that time; blood is still getting to the spinal cord; many patients come in hypotensive – no BP for 40, 50 minutes – while pumping on the chest, yet they are not paralyzed; it's a different animal.*

33 / 1 Does believe the rupture occurred at the time of surgery

33 13-6 Again, there is no indication in the record; they note the BP drops; here they have the BP of 90, then they say they put her left side up, BP suddenly dropped to 40

33 17-13 You have a patient who is losing blood into a pseudoaneurysm who may be their hematocrit is low, blood volume is low, giving fluid too in a completely lying flat position, they are maintaining a BP; you lift them up, shift all the fluid out in a different direction; that is why their BP drops; you can take a normal patient, put them in a different . . . .

33 / 16-17 Agrees its like Postural Hypotension; does not say the BP dropped to 30, the chest tubes filled. That is a free rupture

33 / 18-22 In his patient that died in the OR, he had almost 3 ltrs of blood in his chest tube; that is a free rupture; *This I believe here because they got in, they clamped her, they don't give another BP until the clamp I don't think.*

33 / 24 *No, until after the clamp they have.*

34 17	Doesn't believe the hematoma rupturing lengthened the repair
34 19-16	Believes the hypotension speeded upon at least the first part of the operation because one *doesn't spend a whole lot of time prepping and draping – doing everything perfect; got to get the chest open as quick as you can to get the clamp on the aorta. The 25 minutes you would have taken to open the chest, you now drop it down to 5 minutes. You get in there a clamp the aorta.*
34 / 21	Doesn't know that the hematoma ruptured as there is no note in the record indicating there was blood everywhere
35 11	Is not saying it was an error for the rupture not to be reported; the surgeon was there, he was not
35 / 8	The rupture would not have increased the time she had to be cross-clamped
35 115-18	Has used 3 different techniques to repair a transected descending thoracic aorta; he's done it clamp, clamp, sew; left arteriallfemoral artery bypass; systemic hypothermia, circulatory arrest
35 / 20-23	The left arterial to femoral artery bypass is done to keep the BP higher in the lower extremity to try to protect the spinal cord
35/24-36/4	Systemic hypothermia, circulatory arrest is when the patient is put on femoral artery, venous bypass, the temperature is brought down to 14 degrees, the blood is all drained out of the body, the cold temperature not only protects the brain but protects the spinal cord while you are doing the repair
36 / 10	The clinical situation of the patient dictates which method he uses
36 / 14-18	Two examples of when he would do clamp, clamp sew if the patient had previous bypass surgery and he couldn't get to the left atrium very easily or if the patient had peripheral vascular disease and he couldn't get to the femoral artery very well
36 / 19-21	He'll use CCS if it can be done under 30 minutes
37 / 6	He would use CCS because the others which are called spinal cord sparing are not possible due to prior surgeries or a person's vessel status
37 / 9	Does prefer the bypass method
37 / 13	Doesn't agree the literature shows that the bypass alleviates some of the potential of paraplegia
37 / 15-19	The literature shows paraplegia with every technique he described. He feels more comfortable if he does a patient and they have paraplegia and he can say he did everything he knew how to prevent it

37 / 23 Has not reviewed any recent literature when reaching his opinion in this case

3813 Claims to keep up with literature on a monthly basis

3816 But he didn't do that in this case

38 / 9 Probably will not do one prior to his trial testimony

38 114 Does not believe the hypotensive that began at 9:10 and continued through the surgery contributed to Marla's paraplegia

38 120 Does not plan on educating the jury on how the surgery is done; he will not be volunteering that

39 / 19 Agrees there is a high index of suspicion of injury to the great vessel when a patient has a decelerating chest crush injury

39 / 25 Agrees that it is important with a high index of suspicion to follow up diagnostically because they aren't that many pathonemonic findings that make you think that the person had that injury

4012 Did look at the CT scan

4014 Did not see anything on it

40 114 Believes that CTs can be used both as diagnostic as well as screening

40/22-41/6 To refer a patient to the angiography, it largely depends on the individual clinician, his judgment matching what he is seeing on the CT scan, what he is seeing in the patient, finally making a decision of his comfort level as to whether or not he fully explained what he is seeing; if he feels comfortable with what the radiologist is telling him, what he sees on the CT scan himself matches it up to his patient, then he's done; if he doesn't then the burden of proof is on him to prove yes or no to explain what he's got

41 / 10 For Anastasi to refer a patient for an arteriogram, it would depend upon what the patient looked like and how certain he felt the radiologist was about the report

41 / 14-18 Regarding what the patient looks like, if the patient is persistently hypotensive, with a persistent drop in hematocrit, progressively enlarging chest xray, mediastinal shadow on chest xray, that might be a little bit more uncomfortable; he might want to proceed to the arteriogram

41 / 20 Anastasi thinks he viewed one chest xray fi-om this case

41 / 22 **Did see a widened superior mediastinum on the xray**

42 / 3-6 **Doesn't think a widened mediastinum indicates that there probably is a transection, he thinks it should highlight one to think there might one going on.** *You should do a test to determine whether or not that is going on.*

42 / 21-24 Does not know the numbers for the CTs reliability in determining or demonstrating if something is going on with the descending aorta

43 / 2 Anastasi had made a couple of his diagnosis in the cases he worked on by CT

43 / 4 They other couple were made by arteriogram

43 / 9 It was his decision as the surgeon to refer the patient for an arteriogram

43 / 11 The radiologist never documents it; they look at the pictures, the surgeons are the clinicians

43 / 17 The ones he diagnosed by CT, he was called and told there was a transected aorta

43/21-4411 *The patient had come through the ER; they had a wide mediastinum and the CT was ordered; the next call was from the ER doctor saying this lady is down here, she has a transected aorta on CT; next thing I say is fine, I call in the team, send her to OR. That is how we handle it.*

Deposition concluded.