CASE WESTERN RESERVE UNIVERSITY
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Dale L. Kwarciany
Jacobson, Maynard, Tuschman and Kalur
1001 Lakeside Avenue, Suite 1600
Cleveland, OH 44114-1192

Re: Ella Ruth Weatherspoon, Executrix, etc. vs. Cleveland Clinic Foundation et al.
Your file #78853

Dear Mr. Kwarciany,

I have reviewed the material in the above case including the outpatient and inpatient charts from the Cleveland Clinic, the inpatient charts from Meridia Huron Hospital, the autopsy report, and the reports of Drs. Harris and Peppercorn.

Mr. Weatherspoon was a 64 year old man with a history of abdominal surgeries dating back to 1977, and episodes of abdominal pain, nausea and vomiting dating to at least 1983. Initially, he presented with pancreatitis and a pancreatic cyst, and underwent a drainage procedure in 1977. This surgery was followed by multiple bouts of abdominal pain and pancreatitis. In 1982 he presented with peptic ulcer disease and underwent an antrectomy and vagotomy with Billroth II anastomosis at what was then known as Huron Road Hospital. At that time he was described as being 40 pounds underweight. He continued to have significant abdominal symptoms and he eventually underwent a Whipple procedure and drainage of a pancreatic cyst at Huron Road Hospital in 1983. Following his multiple surgeries the patient continued to have persistent abdominal pain, nausea and vomiting, and was evaluated as an inpatient at Huron Road. He was treated with multiple medicines, none of which was consistently effective and he

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was discharged on Haldol for his symptoms. He was referred to a surgeon at the Cleveland Clinic for further evaluation in 1983.

His initial evaluation at the Cleveland Clinic was in 5/83. At that time he had persistent abdominal pain, nausea and vomiting. After this initial evaluation he was referred back to his physicians at Huron Road, who did multiple investigations for similar symptoms and tried other therapies. His physician at Huron Road referred him to a gastroenterologist at the Cleveland Clinic in 1984. He was admitted to the Cleveland Clinic in 1984 and 1985 for evaluation of abdominal pain, nausea vomiting and weight loss. He continued to be followed by physicians at Huron Road. In a letter to the GI Clinic at the VA Hospital from a physician at the Cleveland Clinic in 1986, his ongoing symptoms of abdominal distress were described, and his weight was noted as 125 pounds.

Mr. Weatherspoon underwent continued evaluation at the Cleveland Clinic and in 1986 a feeding tube was placed for nutritional support. Records indicate Mr. Weatherspoon continued to undergo evaluation at the Cleveland Clinic from 1988 for continuance of the symptoms that dated back to 1982 or before. He underwent a gastrectomy in 1990 for continuation of his symptoms. He also underwent multiple upper and lower endoscopies to evaluate his symptoms. His serum albumin was in the mid-to-low two's in 1990-1992.

In 1993 Mr. Weatherspoon was admitted under the service of Dr. Chung with confusion and emaciation. Dr. Chung enlisted the Department of Gastroenterology in the management of his GI syndrome and nutritional status.

He was admitted to the Cleveland Clinic 3/22/94-4/1/94 and 4/29/94-5/9/94 and underwent further evaluation of his GI syndrome as well as symptomatic therapy.

On 5/12/94 Mr. Weatherspoon presented to the Meridia Huron Emergency Room with hypotension, hypothermia, dehydration and unresponsiveness. In consultation with the family, initially management was focused on comfort measures only, but after two days, investigations were begun which revealed severe metabolic acidosis and acute renal failure. He was then treated aggressively with hydration and later TPN through a central venous catheter. He was started on ceftriaxone on 5/13, which was changed

to ciprofloxacin on 5/15. Consultants from Infectious Diseases, Endocrinology, Nephrology and Surgery were involved in his care. The Infectious Disease Consultant wrote that his diarrhea was most likely antibiotic induced. The Nephrology consultant wrote that his renal failure was most likely due to his hypotension on admission. His condition improved, and he was described as talkative and coherent but still weak on 5/19/96. His renal function was improving. He spiked a fever to 39°C on that day, and his white blood cell count increased to 21,000, and increased to 36,000 by the next day. He was treated with ciprofloxacin, clindamycin and metronidazole. Blood cultures obtained around that time eventually grew Enterococcus sp. (antibiotic sensitivities were not available -- it is not clear if the Enterococcus was sensitive to the antibiotics he was given after the report of positive blood cultures). He was given a dose of vancomycin. The Endocrine, Infectious Diseases and Nephrology consultants all wrote that in the morning of 5/20 that he "looked better." The I.D. consultant also noted increased pulmonary infiltrates on 5/20. He expired on 5/21/94, and the family requested an autopsy restricted to the abdomen. The provisional autopsy report included mention of "end stage pancreatitis" and "acute and chronic enterocolitis."

Mr. Weatherspoon's condition in 1994 was a result of a process of gastrointestinal and pancreatic dysfunction that dates back to at least 1977, and malnutrition that dates to at least 1983. His multiple surgeries over the years left him with severely impaired gastrointestinal (particularly pancreatic) function and chronic malnutrition. It is highly probable that 1994 his diarrhea was due to a combination of low albumin and enteral feedings, which is a well-described syndrome. There was no other treatable diagnosis that would explain his diarrhea found at autopsy. The "acute and chronic entercolitis" is a non-specific finding that can be explained by his multiple courses of antibiotics, sepsis and the hypotension present on admission to Meridia Huron.

By 1994 his albumin was less that two and his cholesterol less than 50; both lab values indicate a very poor prognosis. The survival of patients admitted to the hospital with albumin and cholesterol at this level is less than 50%. As mentioned above, his severe malnutrition was due to an almost 20 year history of extensive abdominal surgeries involving his stomach and pancreas, and a similar number of years of abdominal pain, nausea and poor oral intake. Patients with severely impaired nutrition are at high

risk for a variety of infectious complications, and the Enterococcal line sepsis that developed at Meridia Hillcrest Hospital was a typical complication for patients in his condition.

Dr. Harris, expert for the plaintiff, states that the care of Mr. Weatherspoon at the Cleveland Clinic during his last admission was substandard in that he was placed on gentamycin and levels were not checked. During the entire period of time that Mr. Weatherspoon was on gentamycin, he had daily assessment of renal function, which remained normal. Daily assessment of renal function is an acceptable method for assessing renal toxicity during aminoglycoside administration. It is highly likely that the aminoglycoside administration that ended on 5/5/94 with documented normal renal function did not contribute significantly to his renal failure detected after he was admitted to Meridia Huron. Dr. Harris stated that Mr. Weatherspoon should have been moved to the ICU when he was found with decreased mental status during his last admission to the Cleveland Clinic. There were no hemodynamic, respiratory or other usual indications for admission to an ICU, and the management of Mr. Weatherspoon on the regular ward did not violate the standard of care. Dr. Harris stated that Mr. Weatherspoon should not have been restarted on Darvocet. The evidence that Darvocet contributed to his change in mental status in the hospital is unclear, and there is no evidence that this contributed to his last presentation. Dr. Harris stated that Enterococcus was not a usual cause of line infections. In fact, Enterococcus sp. are highly associated with line infections, particularly in debilitated patients who have received multiple courses of antibiotics.

Dr. Peppercorn states that a more extensive evaluation, including endoscopies, should have been undertaken because Mr. Weatherspoon's presentation of malabsorption and diarrhea was new. Mr. Weatherspoon had undergone multiple tests for GI dysfunction and malnutrition in the two years prior to his presentation, including multiple endoscopies. Dr. Peppercorns statements would be more appropriate for a patient presenting *de novo* with Mr. Weatherspoon's symptoms. No specific etiology for his diarrhea was found during his last admission at Meridia Huron, despite multiple investigations, and no specific diagnosis was found by examination of the GI tract at autopsy.

Neither of the plaintiffs' experts were able to name a diagnosis that was missed by the physicians at the Cleveland Clinic, despite the patients undergoing an autopsy. In fact, there is no distinct pathologic process that was discovered at autopsy that was (a) missed by the physicians at the Cleveland Clinic, (b) is treatable, or (c) contributed to Mr. Weatherspoon's death. The only specific finding at autopsy was "end stage pancreatitis," which is the result of a process that began in at least 1977.

In summary, Mr. Weatherspoon's hospital admissions in 1994 were the result of an end-stage condition resulting from pathologic processes and multiple surgeries dating from at least 1977. The prognosis of patients with his degree of long-standing nutritional deficits is very poor. His terminal event was catheter-related sepsis. The management of Mr. Weatherspoon at the Cleveland Clinic in 1994 did not directly contribute to his death and did not violate the standard of care.

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