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IN THE COURT OF COMMON PLEAS  
CUYAHOGA COUNTY, OHIO  
MARY LOU ZIMMERMAN,  
et al.,  
Plaintiffs,  
JUDGE BURNSIDE  
-vs- CASE NO. 399411  
THE CLEVELAND CLINIC FOUNDATION,  
Defendant.

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Deposition of ROBIN K. AWRY, M.D., taken as if  
upon cross-examination before Laura L. Ware, a  
Notary Public within and for the State of Ohio, at  
The Cleveland Clinic Foundation, 9500 Euclid Avenue,  
Room S32, Cleveland, Ohio, at 2:35 p.m. on Monday,  
September 11, 2000, pursuant to notice and/or  
stipulations of counsel, on behalf of the Plaintiffs  
in this cause.

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-and-

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On behalf of the Plaintiffs;

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On behalf of the Defendant.

EXHIBIT INDEX

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ROBIN K. AWRY, M.D., of lawful age, called  
by the Plaintiffs for the purpose of  
cross-examination, as provided by the Rules of Civil  
Procedure, being by me first duly sworn, as  
hereinafter certified, deposed and said as follows:  
CROSS-EXAMINATION OF ROBIN K. AWRY, M.D.  
BY MR. LINTON:  
Q. Dr. Avery, we meet just a moment ago. My name is  
Bob Linton. Together Mark Ruf and I represent Mary  
Lou Zimmerman and her husband, Sherman Zimmerman, in  
a case that's been filed against The Cleveland  
Clinic Foundation. We're here today to take your  
deposition.

Have you ever had your deposition taken  
before?

A. Not in this case.

Q. Okay. I assumed that was the case, because one of  
us would have taken it.

A. Right.

Q. But how about in other cases?

A. Yes.

Q. Now, how many times have you been deposed?

A. Once. I'm sorry, twice if we count the car  
accident. I was a witness to a car accident.

Q. Let's exclude that.

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A. One medical case.

Q. Was that in connection with your employment here at  
the Clinic?

A. No.

Q. What was your involvement in the other case?

A. I was a friend of the patient.

Q. So what was your involvement in that case?

A. Oh, the other case, a patient was admitted to  
Cleveland Clinic on the Kaiser service, which is a  
complex relationship here, and I came by as a friend  
and phoned his physicians and asked them to change  
his antibiotics, although I was not his treating  
doctor, so ultimately that patient sued the Kaiser  
physicians and I ended up testifying, being  
deposed.

Q. In that case?

A. In that case.

Q. Was that a malpractice case filed by your friend  
against Kaiser?

A. Yes.

Q. Was the Clinic a named party in that case, to your  
knowledge?

A. It was initially but it was dropped.

Q. The case proceeded against Kaiser?

A. Correct.

5

1 Q. What was the infectious disease issue in that case?  
2 A. Can I just ask a question?  
3 Q. Sure.  
4 THE WITNESS: Am I allowed to answer  
5 this without breaking the confidentiality?  
6 MS. DISILVIO: I don't want you to give  
7 the patient's name.  
8 THE WITNESS: Yes.  
9 MS. DISILVIO: You can just very  
10 generally tell Mr. Linton what the infectious  
11 disease issue was.  
12 THE WITNESS: Yes.  
13 Q. Let me be clear about this.  
14 A. Yes.  
15 Q. First of all, you were not a treating physician, you  
16 were just a friend?  
17 A. Correct.  
18 Q. And you offered, I assume, opinions in your capacity  
19 as an infectious disease expert?  
20 A. Correct.  
21 Q. That's what I'm getting at.  
22 A. Well, they didn't ask me as an expert witness. It  
23 was more to determine the facts.  
24 Q. I see, What was the name of your friend?  
25 MS. DISILVIO: Objection. I'm not

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1 going to let her answer that.  
2 MR. LINTON: Well, she gave a  
3 deposition in that case. On what basis would  
4 she not be permitted to identify the case  
5 caption in which she testified in?  
6 MS. DISILVIO: I'll be happy to provide  
7 you the case caption, but I'm not going to let  
8 her give her friend's name on the record.  
9 MR. LINTON: And the basis for that?  
10 MS. DISILVIO: Because she feels  
11 uncomfortable about it, Bob.  
12 THE WITNESS: Well, I just don't know  
13 if -- I mean, during that time that was going  
14 on I was told not to discuss it with anyone.  
15 MS. DISILVIO: Is it still going on?  
16 Q. Has the case been resolved?  
17 A. That's the problem. I heard a rumor it was  
18 resolved, but I haven't seen anything in writing, so  
19 I think it's possible it may still be going on.  
20 Q. Will you provide to Marilena at the end of the  
21 deposition the name of the case, as best you can  
22 remember?  
23 A. Yes.  
24 MS. DISILVIO: And I will be happy to  
25 provide it to you.

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1 Q. All right. That's fine. All this was not at all to  
2 pry into your background, it's simply to make sure  
3 you understand the process we're doing here today,  
4 the deposition. I take it you understand that?  
5 A. Yes.  
6 Q. It's important you understand all the questions that  
7 I ask and it's important that you give truthful and  
8 full answers to the best of your ability. You  
9 understand that?  
10 A. Yes.  
11 Q. It's an open book examination, so if you need to  
12 look at the records or a file or notes or anything  
13 else before answering, please feel free to do that,  
14 okay?  
15 A. Yes.  
16 Q. What did you do to prepare for your deposition  
17 today?  
18 A. The two of us met together today and I met with Mr.  
19 Malone, the two of you together, previously.  
20 MS. DISILVIO: And you need not tell us  
21 about our meetings or the substance of our  
22 discussions, but you can go ahead and tell him  
23 what you reviewed to prepare yourself for  
24 today.  
25 A. I reviewed these records provided to me today, which

8

1 are Xeroxs of the progress notes, the orders, and I  
2 did not review every page, but the substance in the  
3 clinical record. I also reviewed what we have in  
4 our computerized patient record, which includes  
5 microbiologic data, radiologic data and laboratory  
6 data.  
7 Q. The computer data in the records, is that different  
8 than the information that's also been printed out in  
9 the patient's chart?  
10 A. It is a subset of the patient's chart. It doesn't  
11 contain all the progress notes, but it does  
12 summarize the cultures in a neat and accessible way  
13 chronologically.  
14 Q. So it's duplicative of what would be in the  
15 patient's chart, correct?  
16 A. Yes, a portion of what would be in the patient's  
17 chart, that's right.  
18 Q. Have you had a chance to talk to anyone, aside from  
19 the Cleveland Clinic lawyers, to prepare for your  
20 deposition today?  
21 A. No.  
22 Q. Have you talked at any time with Dr. Barnett since  
23 the filing of this lawsuit about this case?  
24 A. No, I have not.  
25 Q. Do you have an independent memory of Mary Lou

9

- 1 Zimmerman as you sit here today?
- 2 A. Yes, I do.
- 3 Q. Tell us what you can remember about her.
- 4 A. Well, it's a pretty general question. Can you be
- 5 more specific?
- 6 Q. Okay. First of all, would you be able to recognize
- 7 her if you saw her?
- 8 A. I don't know.
- 9 Q. Do you remember any conversations that you had with
- 10 her?
- 11 A. I remember that at that time she did not have much
- 12 verbal output. I remember I saw her daily as part
- 13 of my medical rounding for a period of two weeks,
- 14 but my substantive conversations were really more
- 15 with her family. My conversations with her were
- 16 more like asking her did she have pain, was she
- 17 nauseated, asking her to raise her hand or things of
- 18 that nature.
- 19 Q. What do you remember about substantive conversations
- 20 you had with her family?
- 21 A. Again, can you be more specific? I mean, I met and
- 22 spoke with her family because they were always in
- 23 the room, so I talked with them frequently.
- 24 Q. Well, let me ask it this way. For what condition
- 25 were you treating Mary Lou Zimmerman?

10

- 1 A. I was continuing antibiotic treatment started by my
- 2 colleague, Dr. Rehm, for a brain abscess and
- 3 bloodstream and wound infection due to klebsiella
- 4 and staph aureus.
- 5 Q. And was it your belief that those two organisms were
- 6 the cause of both the brain abscess, the bloodstream
- 7 infection, and the wound infection?
- 8 A. That was our belief, yes.
- 9 Q. And does that remain your belief today?
- 10 A. Yes.
- 11 Q. What is the basis for that belief?
- 12 A. I was not the first one to evaluate her, but my
- 13 understanding is that on October 4th she developed,
- 14 or shortly before that, a high fever, had cultures
- 15 taken from the blood, from the wound, from the urine
- 16 and spinal fluid. The blood cultures, two sets,
- 17 grew those same two organisms, the wound grew those
- 18 two organisms, the urine grew a klebsiella
- 19 pneumonia, which is a different organism from
- 20 klebsiella oxytoca, the same family, and shortly
- 21 thereafter her CT scan evolved to demonstrate an
- 22 abscess in the right frontal lobe.
- 23 Q. And what antibiotic treatment did you continue to
- 24 treat Mary Lou Zimmerman for for these three
- 25 infections, or for the infections of these three

11

- 1 locations?
- 2 A. You mean initially or later on? She had a variety
- 3 of antibiotic changes.
- 4 Q. Okay. Let's start initially.
- 5 A. Okay. When I first took over she was receiving
- 6 Oxacillin and Ceftriaxone. This was on 10 --
- 7 sorry. Let me just look at the record. I took over
- 8 on 10-19 and she was on Oxacillin and Ceftriaxone at
- 9 that time.
- 10 Q. And did her brain abscess ultimately respond to that
- 11 treatment?
- 12 A. It responded partially.
- 13 Q. Does that further support your opinion that the bugs
- 14 that were causing that abscess were the same as what
- 15 were cultured in the blood and on the wound?
- 16 A. Yes.
- 17 Q. Did anybody in infectious disease here at the Clinic
- 18 to your knowledge express a different opinion?
- 19 A. About -- I'm sorry, can you clarify that, please?
- 20 Q. Sure. About the bugs that were causing the brain
- 21 abscess.
- 22 MS. DISILVIO: In other words, were
- 23 they something other than klebsiella oxytoca
- 24 and staph aureus?
- 25 MR. LINTON: Correct.

12

- 1 A. I don't recall anyone expressing that opinion.
- 2 Q. Can we agree that based on your medical experience
- 3 that with reasonable medical probability the
- 4 likely--
- 5 - - - -
- 6 (Off the record.)
- 7 - - - -
- 8 A. Sorry to interrupt you.
- 9 Q. We can agree that the most likely organisms causing
- 10 the brain abscess were the klebsiella and the staph
- 11 that you just identified, correct?
- 12 A. Yes.
- 13 Q. Can we also agree that those organisms most likely
- 14 came from the same source?
- 15 A. I can't say that for sure.
- 16 Q. Would you say it's probably from the same source?
- 17 A. I would say it's likely, but I can't say it
- 18 conclusively.
- 19 Q. Why do you believe it was likely that they would
- 20 come from the same source?
- 21 A. Well, it's unusual to have two simultaneous
- 22 infections at exactly the same moment from different
- 23 sources, although that can occur.
- 24 Q. Far more likely to be from the same source?
- 25 A. I would say so. I'd say likely.

13

1 Q. Now, Dr. Barnett told us that there were three  
 2 possible sources for these bugs, that would be  
 3 direct inoculation at the time of surgery from a  
 4 contaminated probe, that would be a post-op wound  
 5 infection or a bacteremia. Would you agree that  
 6 those are the three likely causes of the infections  
 7 you were treating?  
 8 A. Yes.  
 9 Q. Are you able to say which of those three is the most  
 10 likely?  
 11 A. No.  
 12 Q. Dr. Barnett says that her clinical picture is  
 13 consistent with an infection from a contaminated  
 14 probe at the time of surgery. Do you agree with  
 15 that?  
 16 MS. DISILVIO I'm going to object to  
 17 the characterization of Dr. Barnett's  
 18 testimony. With that objection, you may  
 19 answer.  
 20 A. I don't know.  
 21 Q. Well, let me ask it this way. Do you believe that  
 22 her clinical picture is inconsistent with there  
 23 being contamination of the probe at the time of the  
 24 surgery?  
 25 MS. DISILVIO Clinical picture at what

14

1 time?  
 2 MR. LINTON: At any time during the  
 3 time she was here at the Cleveland Clinic.  
 4 A. I really think it could have been any of the  
 5 possibilities we mentioned.  
 6 Q. So her picture is entirely consistent with it coming  
 7 from a contaminated probe at the time of the  
 8 surgery?  
 9 A. That and the other possibilities also.  
 10 Q. What about her -- strike that.  
 11 What would be the basis for your conclusion  
 12 that it could be caused by a contaminated probe?  
 13 A. I haven't concluded -- oh, that it could be caused?  
 14 Q. Right.  
 15 A. Well, first of all, the general principle is that  
 16 surgical postoperative infections may relate to  
 17 events in the operating room, events later on in the  
 18 postoperative phase regarding the wound, or seeding  
 19 from a distant site. In this case I don't have a  
 20 specific opinion about which of those was the  
 21 cause.  
 22 Q. Just so I'm clear, you cannot state with reasonable  
 23 medical probability which of those three was the  
 24 cause, correct?  
 25 A. Correct.

15

1 Q. How long does it take for a scalp wound, like the  
 2 kind Mary Lou Zimmerman had for her surgery, to heal  
 3 in the ordinary course of events?  
 4 A. My impression is that it varies with the patient and  
 5 in addition neurosurgery patients frequently being  
 6 on steroids may delay wound healing, so it can be  
 7 quite variable.  
 8 Q. What would be the range, in your experience?  
 9 MS. DISILVIO For a neurosurgical  
 10 patient?  
 11 MR. LINTON: For patients like Mary Lou  
 12 Zimmerman, correct.  
 13 A. That's hard for me to say, because I really don't  
 14 get called to see patients that heal without  
 15 problem.  
 16 Q. Well, I assume when you are called and there is a  
 17 problem you have some expectation as to what the  
 18 normal healing process would be.  
 19 A. True, but I actually deal a great deal with  
 20 immunocompromised patients, so it doesn't surprise  
 21 me if a wound hasn't healed after some weeks.  
 22 Q. Did the wound in Mary Lou Zimmerman's case heal  
 23 initially, the scalp wound?  
 24 A. I can only speak to the time that I saw her on the  
 25 19th of October. At that point it was healed,

16

1 however, I cannot speak to the healing time before  
 2 that.  
 3 Q. And when you say was healed, all four incisions?  
 4 A. To the best my recollection. Or if they weren't  
 5 completely healed, they were close enough that they  
 6 did not look worrisome to us.  
 7 Q. Assuming that the cause of an infection like this is  
 8 bacteremia, how do the organisms get in the blood;  
 9 how could that happen?  
 10 A. Well, if the organisms are present at some other  
 11 site where they are infecting, they may enter the  
 12 bloodstream in a variety of ways, but it is also  
 13 more common to have a bacteremic infection when  
 14 somebody is on steroids.  
 15 Q. And what's the source of the infection?  
 16 A. I'm sorry, of which infection?  
 17 Q. When they're on steroids, how do the organisms  
 18 actually get into the blood?  
 19 A. Right. Really, there can be a number of sources. I  
 20 did not see the patient at the time that she had  
 21 this infection, so it's difficult for me to comment  
 22 on what other potential sources she could have had.  
 23 Q. Did you form an opinion at any time during your  
 24 treatment of Mary Lou Zimmerman about which of the  
 25 three sources of -- strike that.

17

19

1 Did you form an opinion at any time during your  
2 treatment of Mary Lou Zimmerman as to which of the  
3 three causes of the infection were the most likely?

4 A. I don't recall that I did.

5 Q. Do your notes reflect that you did?

6 A. I don't believe so.

7 Q. How did this infection happen?

8 A. I don't know.

9 Q. Do you have any thoughts as to how it happened?

10 MS. DISILVIO: Objection.

11 A. Well, to repeat what I said to you a little earlier,  
12 if I may --

13 Q. Don't necessarily repeat anything you two discussed  
14 it private, but just tell me your own thoughts.

15 A. Sure. This is my own thoughts.

16 MS. DISILVIO: And I'm going to

17 object. Other than the three things she's  
18 already told you, you may answer the question  
19 again.

20 A. Okay. There is no sterile technique in the world  
21 that is a hundred percent guaranteed of no germs  
22 because we're dealing with things like skin, which  
23 is a nonsterile surface to begin with, and I think  
24 that no matter what techniques are used bacteria can  
25 get into a wound and bacteria can turn up in the

18

1 operating room, albeit at a very low wound infection  
2 rate, nonetheless this can occur despite all of our  
3 good intentions. My general thoughts about  
4 postoperative wound infections is that they happen  
5 and that that is not necessarily due in any one case  
6 to an error.

7 Q. We can agree that breach in sterile techniques can  
8 cause an infection, correct?

9 A. That's true, correct.

10 Q. So for example, if the probe in this case was not  
11 properly sterilized, that could have caused this  
12 infection, correct?

13 A. It is possible.

14 Q. Likewise, if there was a breach in sterile technique  
15 and the patient was not properly prepped, that too  
16 could cause this infection, correct?

17 A. It is possible.

18 Q. Likewise, if there was a breach in sterile technique  
19 and the physician or one of the assistants failed to  
20 properly scrub, that too could lead to this type of  
21 infection?

22 A. That is possible.

23 Q. And likewise, if in the postoperative period during  
24 a dressing change proper sterile technique was not  
25 followed, that too could cause this type of

1 infection?

2 A. That is possible.

3 Q. And have you ever seen a record that you've reviewed  
4 here at the Cleveland Clinic that actually stated  
5 that there was a breach in sterile technique? Is  
6 that information something that's typically  
7 charted?

8 A. Yes, I actually recall -- it was actually at my  
9 previous institution where I trained as an  
10 infectious disease fellow.

11 Q. Up at Harvard?

12 A. At Massachusetts General Hospital, yes.

13 Q. How long have you been at the Cleveland Clinic?

14 A. Since 1993.

15 Q. How many postoperative wound infections have you  
16 treated or assisted in the treatment of?

17 A. I don't know the number, but certainly there have  
18 been numerous ones over the years. We see a huge  
19 volume of patients of all varieties, some are  
20 postoperative, many are not.

21 Q. Would it be fair to say you've seen more than a  
22 hundred post-op wound infections since 1993?

23 A. I'd really have to go back and look at our numbers.  
24 I can't give you a good estimate.

25 Q. Would it be more than 50?

20

1 A. I'd have to look at the numbers.

2 Q. Aside from the one incident you just pointed out at  
3 Harvard, are you aware of any time that's been  
4 charted in the Cleveland Clinic record that there  
5 was a breach in sterile technique in any of the  
6 cases in which you were called to treat or assist in  
7 the treatment of a post-op wound infection?

8 A. Not that I can recall.

9 Q. Would you agree that klebsiella oxytoca is an  
10 unusual organism to have in a post-op wound  
11 infection? Strike that.

12 Would you agree that klebsiella oxytoca is an  
13 unusual organism to have in a post-op infection,  
14 neurosurgery case?

15 A. Neurosurgery, I'd say it is, it's unusual, but it's  
16 not unheard of.

17 Q. Have there been any other neurosurgical cases that  
18 you've been involved with here at the Cleveland  
19 Clinic that have had that organism in a post-op  
20 infection?

21 A. Let me think back. In preparing for this I didn't  
22 go back over all the other cases I've treated over  
23 the years, so I don't recall other bacteriology.

24 Q. Have you been involved in any infection control  
25 committees here at the Cleveland Clinic that have

21

1 addressed klebsiella infections here at the  
 2 hospital?  
 3 A. No, I personally have not.  
 4 Q. Have you reported at all to those committees?  
 5 A. I consult with them periodically, but I don't recall  
 6 speaking with them about klebsiella specifically.  
 7 Q. How about Dr. Barnett's procedures?  
 8 A. No.  
 9 Q. How about stereotactic procedures?  
 10 A. No.  
 11 Q. Have you been involved in treating any other post-op  
 12 neurosurgery infections involving psychosurgery  
 13 by --  
 14 MS. DISILVIO: Wound infection?  
 15 Q. Post-op infections, either wound or abscess,  
 16 relating to psychosurgery, cingulotomies or  
 17 capsulotomies?  
 18 A. I don't recall any others of that nature.  
 19 Q. Is the klebsiella oxytoca an organism typically  
 20 found on the scalp?  
 21 A. It's most commonly found in the colonic and  
 22 intestinal flora. Klebsiella is a normal inhabitant  
 23 of the gut bacterial flora, however, for people who  
 24 are debilitated, elderly, diabetic or  
 25 immunocompromised, they may be more likely to have

22

1 gram negative bacteria on widespread areas of their  
 2 skin.  
 3 Q. And why is that?  
 4 A. Well, partly maybe from issues of hygiene and self  
 5 inoculation, and in addition they may just be less  
 6 resistant to colonization by those organisms  
 7 elsewhere.  
 8 Q. Well, let's talk specifically about Mary Lou  
 9 Zimmerman. Did you know she had  
 10 obsessive-compulsive disorder?  
 11 A. Yes, I did.  
 12 Q. And what was your understanding as to the nature of  
 13 her disorder?  
 14 A. I really don't have all the details regarding that.  
 15 Q. Do you know she had an obsession with cleanliness?  
 16 A. I did not know that.  
 17 Q. Were you aware of any hygiene problems that she had  
 18 when she presented here for surgery?  
 19 A. I didn't see her when she presented.  
 20 Q. Do you have firsthand knowledge of any, based on  
 21 your review of the record?  
 22 A. All I can mention is that it's mentioned in one of  
 23 the notes that she did have some fecal incontinence  
 24 at some time during the admission.  
 25 Q. Was that pre-op or post-op?

23

1 A. That was post-op.  
 2 Q. Anything to suggest she had any problems with  
 3 hygiene pre-op?  
 4 A. I really can't say I reviewed the record as to  
 5 that.  
 6 Q. So you don't know of any as you sit here?  
 7 A. I don't know.  
 8 Q. Any problems that you know of Mary Lou Zimmerman  
 9 having relating to self inoculation before surgery?  
 10 A. I don't know.  
 11 Q. Anything about her medically that would make her  
 12 less resistant than the normal population with  
 13 respect to a gram negative bacteria?  
 14 MS. DISILVIO: Pre-op or post-op?  
 15 MR. LINTON: Pre-op.  
 16 A. I really don't know enough about her pre-op status  
 17 to say that.  
 18 Q. You don't know of any as you sit here?  
 19 A. I don't know enough about her post-op status.  
 20 MS. DISILVIO: Pre-op.  
 21 A. I'm sorry, pre-op.  
 22 Q. But you don't know of any as we sit here, correct?  
 23 A. Correct.  
 24 Q. Is there any reference anywhere in the records that  
 25 you're aware of that Mary Lou Zimmerman may herself

24

1 have been contaminating her wound site after the  
 2 surgery?  
 3 A. In terms of a direct description of this, no.  
 4 Q. How about any reference at all in the record to her  
 5 contaminating her own wound site?  
 6 A. Not that I'm aware of.  
 7 Q. Were you aware during the two-week continual basis  
 8 you saw her of her in any way contaminating her own  
 9 wound site?  
 10 A. No, I was not.  
 11 Q. Was she compliant with the medical treatment, to  
 12 your knowledge?  
 13 A. Well, speaking of the period from October 19th to  
 14 November 1st, which was well after the events that  
 15 occurred, I don't recall truthfully whether she was  
 16 compliant with anything or not or whether she may  
 17 have refused medications at times. I don't recall.  
 18 Q. Do you have any chart in your records during that  
 19 two-week period of her being noncompliant?  
 20 A. I haven't reviewed the records with that in mind.  
 21 Q. Before your deposition I assume you reviewed all  
 22 your entries for that two-week period, didn't you?  
 23 A. I looked at my notes, yes, but I didn't read every  
 24 other note.  
 25 Q. In terms of your notes, did you note her being

25

- 1 noncompliant during that time period?
- 2 A. No, I did not.
- 3 Q. Is that a significant finding that you ordinarily
- 4 note, if in fact she had been noncompliant with your
- 5 treatment during that time?
- 6 A. I would not necessarily have known or commented on
- 7 that.
- 8 Q. That's not something that you typically put down?
- 9 A. Not necessarily.
- 10 Q. Do you have an independent memory as you sit here of
- 11 her being noncompliant during that time?
- 12 A. I really can't recall.
- 13 Q. Would you agree that if Mary Lou Zimmerman's surface
- 14 wound had healed before October 4th of 1998 it was
- 15 unlikely to be the source of her infection?
- 16 A. No, I would not agree with that.
- 17 Q. And why is that?
- 18 A. Because we sometimes see wounds that look innocent
- 19 actually turn out to be sources of infection.
- 20 Q. Have you ever been present during this type of
- 21 surgery?
- 22 A. No.
- 23 Q. Have you ever been present during neurosurgery?
- 24 A. Yes.
- 25 Q. When was the last time you were physically present

26

- 1 during neurosurgery?
- 2 A. It must have been a long time ago. We are
- 3 occasionally called to the operating room to assist
- 4 with delivering culture specimens, but it would have
- 5 been a while ago.
- 6 Q. When you say a while ago, how long a time are we
- 7 talking about?
- 8 A. Probably at least four or five years.
- 9 Q. Do you know what techniques are used by the
- 10 neurosurgeons to follow proper sterile technique
- 11 before doing this type of surgery?
- 12 A. No, I really don't.
- 13 Q. Do you know what techniques are used at Cleveland
- 14 Clinic to see that the probe and other surgical
- 15 equipment are properly sterilized before the
- 16 surgery?
- 17 A. No, I don't.
- 18 Q. And do you know how the skin is prepped for this
- 19 patient before this type of surgery is performed?
- 20 A. No.
- 21 Q. Why was it that you were originally called in to
- 22 consult on this case on October 19th?
- 23 A. We have a routine switch in our infectious disease
- 24 consult service every two weeks, and I was scheduled
- 25 to take over for Dr. Rehmat that time.

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- 1 Q. And is that likewise why Dr. McHenry took over for
- 2 you?
- 3 A. Correct.
- 4 Q. Before taking over Mary Lou Zimmerman's case, did
- 5 you have a discussion with Dr. Rehm about her
- 6 condition?
- 7 A. I'm sure I did because we always sit down and have a
- 8 sign-out session, but I don't recall what she said.
- 9 Q. Likewise, before Dr. McHenry took over, did you have
- 10 a session with him to discuss the status of her
- 11 condition?
- 12 A. I'm sure I did, but I don't recall the contents of
- 13 that either.
- 14 Q. Can you give me some idea in a normal week in the
- 15 Clinic back in 1998 how many patients you would have
- 16 consulted for?
- 17 A. At anyone time we might be following between 15 and
- 18 25 patients, occasionally more.
- 19 Q. Do you recall any discussions you had with the
- 20 family about the cause of the infection?
- 21 A. Yes.
- 22 Q. What can you tell us about that?
- 23 A. I recall that they wanted to know what the source of
- 24 the infection was, and I told them similarly to what
- 25 I just said, that there were three major general

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- 1 possibilities for a source but that often in
- 2 practice we don't have a good way of determining
- 3 which of those it could have been.
- 4 Q. Who was present during that discussion?
- 5 A. I don't remember.
- 6 Q. Was Mr. Zimmerman there, Sherman Zimmerman?
- 7 A. It's very possible, because I remember speaking with
- 8 him, but I don't know if it was that exact
- 9 conversation. I remember speaking with a number of
- 10 different family members over time, but I don't
- 11 recall exactly which conversation went with which
- 12 family member.
- 13 Q. Are you able to pinpoint a date of this conversation
- 14 based on the notes in your chart?
- 15 A. I recall that they asked me fairly soon after I took
- 16 over, so it might have been on the second or third
- 17 day, but I can't be sure exactly.
- 18 Q. Did you have more than one discussion with the
- 19 family about the source of infection?
- 20 A. Yes. I recall they repeatedly asked me this
- 21 question, and I gave them really what was the best
- 22 answer I could.
- 23 Q. Did they ever tell you that people at the Cleveland
- 24 Clinic had told them otherwise?
- 25 A. Otherwisethan --

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- 1 Q. Than what you said in terms of the source of the  
2 infection.
- 3 A. No, I don't recall their ever saying that.
- 4 Q. Were you present at any time when any of the  
5 neurosurgeons discussed the source of the  
6 infection?
- 7 A. Yes. There was a family meeting which occurred  
8 shortly after Dr. McHenry took over, in fact I think  
9 it was the first day he took over, and present was  
10 Dr. Barnett, Lori Bell, the social worker, myself,  
11 the psychiatrist, and some family members, I don't  
12 remember exactly which ones, and Dr. Barnett  
13 reviewed the whole course, discussed it with them.
- 14 Q. And what did he say?
- 15 A. I really don't recall exactly what he said.
- 16 Q. Do you recall what he said in terms of the source of  
17 the contamination, the source -- excuse me, the  
18 source of the infection?
- 19 A. I don't recall that he felt there was a definite  
20 source at that time.
- 21 Q. Did he at any time?
- 22 A. Not that I'm aware of.
- 23 Q. Did anybody on neurosurgery, to your knowledge?
- 24 A. Speak to me about a source, no.
- 25 Q. Did anybody in your presence speak to the family

30

- 1 about a source?
- 2 A. Not that --
- 3 MS. DISILVIO: Other than what we've  
4 already talked about?
- 5 A. Other than what we've already talked about, not that  
6 I recall.
- 7 Q. Did you make any requests or assist in any requests  
8 to have the Cleveland Clinic waive any medical  
9 expenses of Mary Lou Zimmerman's?
- 10 A. I don't recall being asked about that. Could I  
11 please refer to my notes of that family meeting? I  
12 think I did leave a note. Let me see if there's  
13 anything else I can add.
- 14 Q. Oh, sure.
- 15 A. Maybe I didn't leave a note. Sorry, I don't find a  
16 note from myself that day.
- 17 Q. Do you know if Mary Lou Zimmerman was given  
18 prophylactics before surgery, prophylactic  
19 antibiotics?
- 20 A. I know she received Ancef, which is Cefazolin, for  
21 48 hours after surgery, which was in her  
22 postoperative orders, but I did not look to see what  
23 her preoperative prophylaxis was, if any.
- 24 Q. Assuming that the most likely cause of her infection  
25 was direct inoculation with a contaminated probe at

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- 1 the time of surgery, what effect would the post-op  
2 antibiotics have on her infection?
- 3 MS. DISILVIO: Objection to the  
4 hypothetical. You may answer.
- 5 A. Well, I don't really think I'm competent to answer  
6 that question.
- 7 Q. Why is that?
- 8 A. I don't know of any data where direct inoculation of  
9 that nature was followed by 48 hours of antibiotics,  
10 so I can't really say whether or not that would have  
11 prevented an infection.
- 12 Q. Can we agree that it would delay the onset of  
13 symptoms from that infection?
- 14 MS. DISILVIO: Objection. You may  
15 answer.
- 16 A. I would say it's possible, but I really can't say  
17 that. I don't have expertise enough to say one way  
18 or the other. I'm sure there is -- I'm sure there  
19 must be research of that nature, I just don't know  
20 it.
- 21 Q. Did you review any medical literature to prepare for  
22 your deposition here today?
- 23 A. No.
- 24 Q. Did you review any medical literature at any time in  
25 connection with your care of Mary Lou Zimmerman?

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- 1 A. I don't recall. I mean, I read all the time, but I  
2 don't remember specifically reading something  
3 regarding her.
- 4 Q. I assume that in your capacity here at the Clinic  
5 you teach fellows and residents in infectious  
6 disease?
- 7 A. Yes.
- 8 Q. If one of your fellows or residents wanted to learn  
9 more about post-op wound infection, what medical  
10 textbooks would you refer them to?
- 11 A. Well, I think rather than textbooks these days we  
12 would do a search and update our literature. A lot  
13 of the literature I trained with now is old, so we  
14 try to get the latest when we can.
- 15 Q. And what medical literature would you refer your  
16 students to?
- 17 A. Well, I'm trying to think what I've looked up  
18 recently that's helpful regarding something like  
19 that. I mean, our basic textbook we refer to most  
20 often is Mandell, Douglas, Barnett, but I wouldn't  
21 say that it is definitive in every word because  
22 things are changing rapidly.
- 23 Q. What about in terms of medical literature, what  
24 journals would you refer your students to?
- 25 A. Journals in general or particular articles?



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- 1 Q. Let's talk particular articles.
- 2 A. Okay. Well, the particular articles that I give my
- 3 students and fellows most often, I have a set of
- 4 articles on catheter related infections, I have a
- 5 set of articles on endocarditis, I have all these in
- 6 the office, if you're interested, sternal wound
- 7 infections.
- 8 Q. Did you say external?
- 9 A. Sternal.
- 10 Q. Sternal.
- 11 A. We do a lot of cardiac surgery here, as you know,
- 12 and my particular specialty is transplant infectious
- 13 disease. So I can cite you to any literature pretty
- 14 much in that field, but I don't recall pulling any
- 15 articles recently on neurosurgical wound infections.
- 16 Q. What journals would you go to if you were
- 17 researching that?
- 18 A. Well, again the surgeon could turn up articles in
- 19 many different journals, but the ID journals we read
- 20 most often include Clinical Infectious Disease,
- 21 Journal of Infectious Disease, New England Journal,
- 22 Annals of Internal Medicine, JAMA, et cetera.
- 23 Q. I want to just go over a few things. I think we've
- 24 covered them, but you cannot tell us how Mary Lou
- 25 Zimmerman got infected, can you?

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- 1 MS. DISILVIO: Objection. Asked and
- 2 answered. You may answer again.
- 3 A. Correct.
- 4 Q. You cannot say when she received the infection?
- 5 MS. DISILVIO: Objection. Asked and
- 6 answered. You may answer again.
- 7 A. You mean when the infection originally started, when
- 8 was the onset? The term received the infection
- 9 was --
- 10 Q. That was vague. You can't tell us when she -- you
- 11 can't tell us the source of the infection, correct?
- 12 A. Correct.
- 13 Q. And if the source -- strike that.
- 14 You can't tell us whether the brain infected
- 15 the surface wound or the surface wound infected the
- 16 brain, correct?
- 17 A. Correct.
- 18 Q. And likewise, you can't tell us whether the brain
- 19 infected the surface wound -- strike that.
- 20 You can't tell us whether the brain infected
- 21 the blood or the blood infected the brain?
- 22 A. Correct.
- 23 Q. Assuming the brain was the cause of the -- strike
- 24 that.
- 25 Assuming that it was a contaminated probe that

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- 1 caused the infection in the brain and that then
- 2 caused the infection on the wound and the brain
- 3 likewise caused the infection in the blood, assuming
- 4 that scenario, what would you expect the spinal
- 5 fluid to show?
- 6 MS. DISILVIO: Objection.
- 7 A. Well, the spinal fluid at this point is going to be
- 8 dependent on the presence of a brain abscess
- 9 regardless of which caused which. I believe the
- 10 spinal fluid was consistent with what we call a
- 11 parameningeal focus, meaning not directed to the
- 12 spinal fluid itself, but contiguous enough to cause
- 13 an infection in an inflammatory pattern, however
- 14 that doesn't speak to what caused what regarding the
- 15 brain abscess.
- 16 Q. So the brain abscess, in effect, spreads to the
- 17 spinal fluid?
- 18 A. No, it doesn't spread in terms of direct bacterial
- 19 spread, but the contiguity inflames the meninges,
- 20 which are the linings in which the spinal fluid
- 21 resides, and that usually causes a moderate
- 22 elevation in the spinal fluid white count, but not
- 23 nearly as high as if you actually had bacteria
- 24 within that fluid itself.
- 25 Q. There's no evidence here that her white blood count

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- 1 was high enough to show an actual contamination of
- 2 the CSF itself?
- 3 A. Correct, although I prefer the term infection rather
- 4 than contamination there, yes.
- 5 Q. And likewise, the presence or absence of the
- 6 infection in the CSF does not say anything about the
- 7 source of the infection?
- 8 A. Correct.
- 9 Q. Tell me, with the bacteremia how does the organism
- 10 get into the back -- excuse me. How does the
- 11 organism get into the blood to begin with?
- 12 A. Well, many different possible ways, depending on the
- 13 source, but usually there's some apparent or
- 14 inapparent breach in some lining somewhere or
- 15 inflammation in some normal lining.
- 16 For example, when a gallbladder is inflamed,
- 17 bacteria present within the gallbladder can take the
- 18 opportunity to traverse the lining and enter the
- 19 bloodstream, or when someone has inflammation or
- 20 ulcers in the colon, then bacteria from the colon
- 21 that normally stay there can proceed through that
- 22 lining and enter the bloodstream. But depending on
- 23 the source and the site, there are many different
- 24 ways that that could occur.
- 25 Q. Based on your treatment of the patient and your

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1 review of the records, did you notice any abnormal  
2 condition or process going on in her gut that would  
3 make her more susceptible to a blood infection?  
4 A. Not that I recall.  
5 Q. What would be the potential sources of the blood  
6 infection or bacteremia for Mary Lou Zimmerman?  
7 A. Well, I can't say that there's any one source that I  
8 can implicate.  
9 Q. What are the potential sources?  
10 A. Of bacteremias in general?  
11 Q. In general that would apply to her case.  
12 A. Right, right. Well, I don't really know how to  
13 apply it to her case since I didn't see her during  
14 this time when she was developing the infection, but  
15 possible sources for bacteremias include lungs,  
16 urine, GI tract, skin, catheter sites or sites of  
17 any other indwelling foreign bodies like chest tubes  
18 or things of that nature, which she didn't have, but  
19 not having seen her again during the initial  
20 evaluation I can't really pinpoint any particular  
21 source that might have been there.  
22 Q. Can you rule out any sources?  
23 A. No.  
24 Q. Did she have, to your knowledge, any abnormalities  
25 in her lungs?

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1 A. No.  
2 MS. DISILVIO: Are you talking about  
3 initially postoperative?  
4 MR. LINTON Yes.  
5 A. I don't know.  
6 Q. How about in her urine?  
7 A. She had a urine culture at the same time as the  
8 bacteremia that grew klebsiella pneumonia, so she  
9 did have a urinary tract infection.  
10 Q. You said she did?  
11 A. Yes.  
12 Q. So doesn't that most likely rule it out as the  
13 source of the bacteremia in terms of probabilities?  
14 A. I actually looked into this because I wondered if  
15 that could, in fact, be the same organism  
16 misidentified by the microbiology lab, and I asked  
17 our head of microbiology, Dr. Procop, P-R-O-C-O-P,  
18 and he said that usually they can distinguish those  
19 pretty readily, but they are similar organisms.  
20 Q. So there is the possibility that they can be  
21 mistakenly identified, in this case they probably  
22 were properly identified?  
23 A. I think that's probably a good way to put it.  
24 Q. And assuming it's a different organism, isn't it  
25 unlikely to be the cause of the infection in the

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1 blood, which is of a different organism?  
2 A. Well, I'm still not sure. I still think it's an  
3 awfully funny coincidence that we should have two  
4 klebsiellas at the same time turning up on exactly  
5 the same day. So despite what our micro director  
6 says, I still wonder, but I certainly have no  
7 definitive way to state that that's the source.  
8 Q. Assuming that the kleb. in the urine was different  
9 than what's in the blood, can we agree that the  
10 urine was likely not the source of the infection in  
11 the blood --  
12 MS. DISILVIO: Objection.  
13 Q. -- just in terms of probability?  
14 MS. DISILVIO. Asked and answered.  
15 Q. We're not talking about absolute certainties, but in  
16 terms of probabilities.  
17 A. Well, I would say that if we knew for sure they were  
18 two different, but that makes it less likely,  
19 however --  
20 Q. Assuming --  
21 MS. DISILVIO. Bob, please let her  
22 finish her answer.  
23 Q. But based on the assumption they are two separate  
24 bugs, then it is likely not the cause of that  
25 infection, correct?

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1 MS. DISILVIO. Doctor, please continue  
2 to answer the question.  
3 A. I'm sorry, let me catch my train of thought.  
4 Q. I'm going to interrupt.  
5 MS. DISILVIO Can you let her finish  
6 her answer? Laura, could you go back and read  
7 me her answer and where we got cut off at the  
8 however.  
9 A. That's okay. I think I remember it.  
10 Q. Go ahead.  
11 A. Assuming that we knew for sure these were two  
12 different bugs, that would make it less likely,  
13 however I have seen cases where one bug in the urine  
14 overgrows and masks the presence of others. I admit  
15 that's unusual, but I can't be a hundred percent  
16 sure.  
17 Q. Do you have any evidence in this case that her skin  
18 was the likely source of the infection in the  
19 blood?  
20 A. No.  
21 Q. Do you have any evidence in this case that her  
22 catheter was a likely source of the infection in the  
23 blood?  
24 A. You mean the intravenous --  
25 Q. Yes.

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- 1 A. No, I don't.  
 2 Q. What about her chest tube; **she** had no chest tube?  
 3 A. She did not have a chest tube. That was just in  
 4 general.  
 5 Q. So that obviously was not the case here, correct?  
 6 A. Correct.  
 7 Q. And do you have any evidence that her GI tract was a  
 8 likely source of her blood infection here?  
 9 A. No, but with the mention of fecal incontinence that  
 10 raises some questions, however I have no direct  
 11 evidence.  
 12 Q. What would be required for fecal incontinence to  
 13 lead to a blood infection?  
 14 A. Well, any kind of inflammation in the colon and  
 15 diarrhea of all sorts. I assume with fecal  
 16 incontinence, they may be talking about diarrhea.  
 17 Diarrhea can damage or injure the lining of the  
 18 intestinal mucosa, and that could potentially allow  
 19 a bacteria to enter the bloodstream.  
 20 Q. What if she had fecal incontinence without  
 21 diarrhea?  
 22 A. Well, again, even from hemorrhoids or small fissures  
 23 near the anus, if she were having difficulty passing  
 24 stool and was straining for example, then stool  
 25 bacteria could potentially enter from the anal

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- 1 area.  
 2 Q. Do you have any evidence in fact that she had  
 3 hemorrhoids or fissures?  
 4 A. No.  
 5 Q. If we could go through your progress notes. Having  
 6 just reviewed the laundry list of possible causes of  
 7 bacteremia, do you agree you have no evidence that  
 8 the blood infection was, in fact, the likely cause  
 9 of the brain abscess or the wound infection in this  
 10 case?  
 11 MS. DISILVIO Well, I'm going to  
 12 object because she's already told you she  
 13 didn't see the patient immediately  
 14 postoperative, but with that objection if you  
 15 can answer it, go ahead.  
 16 MR. LINTON: I understand.  
 17 A. Correct.  
 18 Q. If we can go through the progress notes, I'd like  
 19 you to review for us the notes that you would have  
 20 written or signed.  
 21 A. Uh-huh. Do you want me to read them to you?  
 22 Q. If you would. First of all, the first entry is on  
 23 10-19?  
 24 A. 10-19, correct.  
 25 Q. Okay. If you don't mind, I'm going to look over

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- 1 your shoulder so I can see what you're looking at.  
 2 A. Do you want me to come over to that side?  
 3 Q. There's probably more room on your side.  
 4 A. Okay. 10-19-98, taking over ID consult service from  
 5 Dr. Rehmtoday. Continues on Oxacillin, Ceftriaxone  
 6 for MSSA/klebsiella, that's a slash, MSSA, slash,  
 7 klebsiella.  
 8 Q. Take your time.  
 9 A. Brain abscess and bacteremia. White blood count  
 10 4.46 bears watching. Creatinine 0.6. Plans for  
 11 repeat CT noted, agree with check C diff. So she  
 12 must have had diarrhea because we were ordering a C  
 13 difficile to see if that was the cause of her  
 14 diarrhea. Do you want me to go to the next one?  
 15 Q. Yes.  
 16 A. Okay. 10-20-98, afebrile and stable. Awake,  
 17 staring, not following commands to my exam but  
 18 reportedly more verbal at times. Chest clear, COR,  
 19 no murmur, abdomen soft, plus bowel sounds,  
 20 nontender, Hickman in place, extremities negative,  
 21 skin negative.  
 22 That would have meant no rash because that's  
 23 what we were looking for with the antibiotics.  
 24 Labs, urine 10-19 negative, C diff. 10-18 negative,  
 25 CSF 10-16 culture negative, creatinine 0.6, white

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- 1 count 4.7, CT, will review. No change per  
 2 neurosurgery. Impression--  
 3 Q. Go ahead.  
 4 A. Impression, one, we're at approximately eight  
 5 weeks. Oxacillin, slash, Ceftriaxone for  
 6 MSSA/klebsiella, brain abscess, bacteremia, plans  
 7 for LP noted. Two, relative leukopenia following  
 8 decrease over time, on high dose beta lactam. If  
 9 neurosurg. feels no drainage procedure will be  
 10 necessary, we can set up IV antibiotics at any time  
 11 at rehab facility, if desired by team, with lab work  
 12 faxed to us.  
 13 Q. Let me ask you, was there an issue at this point as  
 14 to whether the abscess should be drained?  
 15 A. I recall that question coming up. I do recall Dr.  
 16 Barnett addressed this during the family meeting  
 17 because the family asked would that have accelerated  
 18 her improvement, and as I recall his answer was that  
 19 that had a chance of making her significantly worse  
 20 neurologically.  
 21 Q. Is that a treatment issue that you defer to  
 22 neurosurgery, or do you make that recommendation  
 23 independent of whether surgery is a necessary form  
 24 of treatment for a brain abscess?  
 25 A. We generally defer to neurosurgery.

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1 Q. Let me just stop for a moment here.  
 2 A. Yeah, we might be missing something here.  
 3 Q. On pages like this, the 10-22-98, it says ID with  
 4 Dr. Avery. Is that written by your resident?  
 5 A. Yes, this is either a medical student or resident on  
 6 our team.  
 7 Q. We'll come back to those entries, but let's just  
 8 look for your entries right now.  
 9 A. Right, right. And I can't find mine from 10-22 for  
 10 some reason. Here's 10-23. Afebrile, above CSF  
 11 culture noted, it is GPC, that means gram positive  
 12 cocci, in pairs and chains, suspect viridans strep,  
 13 likely contaminant since covered by the regimen she  
 14 has been on already. Also only six percent -- only  
 15 six white cells with one percent polys, doubt new  
 16 bacterial infection, however, will check isolate  
 17 identification later today with micro lab. Urine  
 18 negative, C diff. negative, creatinine 0.6, white  
 19 count 3.98, CSF 10-21, glucose 51, protein 73, red  
 20 cells 14, while cells six, one percent polys.  
 21 10-16, glucose 58, protein 46. This is also a CSF,  
 22 I'm sorry. RBC 35, while cells six. On exam,  
 23 comfortable, afebrile, nonverbal. Impression,  
 24 status post craniotomy for OCD, MSSA, slash,  
 25 klebsiella, bacteremic brain abscess, on Oxacillin

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1 and Ceftriaxone, planning six to eight weeks Rx from  
 2 10-4 culture at least until 17-15-98.  
 3 Two, new GPC, pairs and chains, 10-21 CSF,  
 4 suspect viridans strep contaminant, no fever, CSF  
 5 six, white blood cells stable, one percent polys,  
 6 await final identification with micro but suspect  
 7 can discontinue Vanco. soon. We started Vancomycin  
 8 in response to that culture.  
 9 Three, leukopenia, white blood count acceptable  
 10 currently, but if falls much lower might need to add  
 11 GCSF to keep white blood cell up and keep her on  
 12 antibiotics. I am hesitant to decrease doses of  
 13 antibiotics --  
 14 Q. Just take your time.  
 15 A. Doses of antibiotics in this situation. Addendum,  
 16 spoke with patient's husband at length concerning ID  
 17 issues, gave him my office number if further  
 18 questions.  
 19 Q. Do you remember --  
 20 A. That must have been one of those talks. I don't  
 21 recall the exact substance of that. 10-23-98,  
 22 addendum, see my note earlier today, CSF, GPC in  
 23 quotes, has been identified as coag. negative staph  
 24 plus enterococcus, likely laboratory contaminant and  
 25 not new infection, given clinical stability, no

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1 change in CSF, white blood cells and double  
 2 isolate. Agree with repeat LP.  
 3 Q. What does that mean, likely to be lab contaminant?  
 4 A. Oh, that it's not actually from the patient, but  
 5 it's introduced in the processing because the  
 6 culture systems are so sensitive they pick up tiny  
 7 amounts of bacteria. In this case she didn't look  
 8 like she had a new infection, plus when you get two  
 9 bugs that are coag. negative staph it's a frequent  
 10 contaminant. Well, not always. That suggests that  
 11 it was not from that fluid.  
 12 Q. That was a false positive?  
 13 A. False positive, right. That's what we thought.  
 14 10-24-98. Afebrile, drowsy this p.m., pupils react  
 15 appropriately, not following my commands. Chest  
 16 clear, COR, no murmur, abdomen soft, nontender. CSF  
 17 10-24, ten white blood cells, one poly, 92 lymphs,  
 18 five monos, protein 89, glucose 60. By the way,  
 19 that one poly, 92 lymphs, five monos refers to the  
 20 composition of those ten white cells. It doesn't  
 21 mean there were 92 white cells. White blood count  
 22 3.77, micro, 10-24 CSF, diagram stain, few polys, no  
 23 organisms. 10-21, CSF MRSE, slash, ENTC. 10-21,  
 24 urine negative, parentheses, 10-8 CSF was MSSE,  
 25 closed parentheses. Impression, one, klebsiella,

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1 slash, MSSA, bacteremia plus brain abscess, continue  
 2 Oxacillin, staph, Ceftriaxone, six to eight weeks Rx  
 3 at least until 11-15. Two, CSF 10-21 with MRSE and  
 4 enterococcus, suspect lab contaminant. Not same  
 5 coag. negative staph as 10-8 CSF which was MSSE.  
 6 CSF 10-24 also does not suggest new bacterial  
 7 infection.  
 8 Three, leukopenia, would consider discontinuing  
 9 Vanco., which like Oxacillin and Ceftriaxone can  
 10 contribute. And I put on the side would re-check  
 11 LFTs on Oxacillin.  
 12 Q. Okay.  
 13 A. 10-25-98, afebrile, will review CT, repeat CSF,  
 14 culture negative to date. Suspect staph coag.  
 15 negative, slash, enterococcus is contaminant and  
 16 could D/C Vanco. where neurosurg. is comfortable. I  
 17 think I meant if it's already with them. Repeat  
 18 white blood cell pending, but with 3.77 may increase  
 19 when Vanco. discontinued, await liver profile.  
 20 10-26-98, thirty-seven six, lethargic, chest  
 21 clear, COR, no murmur, abdomen soft plus bowel  
 22 sounds, nontender, extremity, PAS on. That's PAS  
 23 stockings. Labs, white blood count up 4.08. LFTs,  
 24 ALT 52, AST 39, bilirubin 0.3, alkaline phosphatase  
 25 88. Micro urine screen positive, UA positive for

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1 yeast, and this is cut off a bit. I think I was  
 2 saying, one, continue Ox., Ceftriaxone until at  
 3 least 11-15, two, Fluconazole 200 QD times three  
 4 days, and I said something about check with ID  
 5 pharmacist, won't change Neurontin level, and  
 6 something about Tegretol level. That's because we  
 7 were starting Fluconazole, the drug interactions.  
 8 10-27-98, temp up to 40 today, no cough,  
 9 sputum, had nondiarrheal stool. Exam, no distress,  
 10 eyes open, won't open mouth, chest clear. COR, no  
 11 murmur, Hickman site clean, nontender, abdomen soft,  
 12 plus bowel sounds, nontender. Extremities, PAS on,  
 13 skin, no rash.  
 14 Labs, 10-27, blood cultures, urine culture  
 15 pending, 10-25 urine, yeast, 10-24 CSF negative,  
 16 creatinine 0.6, 10-26 white blood count 4.08. Chest  
 17 x-ray pending, will review.  
 18 Impression, one, new fever, source not obvious  
 19 to exam. Doubt being off Vanco. briefly had  
 20 anything to do with it since Vanco. is long acting.  
 21 Also, she was not febrile prior to Vanco. Will  
 22 review chest x-ray. No respiratory symptoms.  
 23 Urine, yeast treated since 10-26, doubt cause of  
 24 fever unless positive blood cultures. That means I  
 25 doubted the yeast would be the cause unless it

50

1 showed up in the blood. Hickman site looks fine but  
 2 still could be source, even without rash. Drug  
 3 fever can occur and could be due to any of her  
 4 antibiotics. Less likely with Fluconazole, though  
 5 it was started most recently. Would continue  
 6 Vanco., Ox., Ceftriaxone, Fluconazole pending  
 7 cultures. If looks more septic, would add empiric  
 8 Cipro 400 q 12, or gram negative cultures, MSSA,  
 9 slash, klebsiella, bacteremia and brain abscess.  
 10 10-28-98, T max 40.2 yesterday then afebrile,  
 11 now 38.4, no cough, slash, sputum, no diarrhea per  
 12 nursing staff, looks unchanged, chest clear, COR, no  
 13 murmur, abdomen soft, plus bowel sounds and  
 14 nontender, Hickman site nontender, extremities  
 15 negative, skin negative. Labs, white blood count  
 16 down to 2.94, micro, 10-27 urine plus yeast, 10-27  
 17 blood cultures negative to date, 10-24 CSF culture  
 18 negative, 10-21 CSF coag. negative staph  
 19 enterococcus. Chest x-ray, left pleural effusion.  
 20 Head CT, reported no change, will review.  
 21 Impression, one, new fevers times two days, on  
 22 exam source not evident. Only positive culture  
 23 recently, urine yeast, despite Fluconazole. Blood  
 24 cultures are negative to date, but it can take three  
 25 to four days for yeast to grow, however suspect drug

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1 fever. Sometimes Vanco. can cause in absence of  
 2 rash since we believe that 10-21 CSF was most likely  
 3 contaminant. I'd be comfortable with discontinuing  
 4 Vanco. and reculturing. Note that Vanco. is long  
 5 acting and fevers can persist for two to three days  
 6 after discontinuation.  
 7 Two, persistent fungal UTI, not responsive to  
 8 Fluconazole, would consider low dose Ampho. B, 0.2  
 9 milligrams per kilogram IV, or Ampho. B bladder  
 10 irrigation. Discussed with neurosurg., okayed,  
 11 discontinuing Vanco.  
 12 10-29-98, temps down, 138.4 yesterday, afebrile  
 13 so far today. Off Vanco., on low dose Ampho.  
 14 Family concerned about right arm shaking, increase  
 15 today. Blood cultures are negative to date. White  
 16 blood count pending. 10-27, urine yeast.  
 17 Impression, one, bacteremic klebsiella, MSSA,  
 18 right frontal brain abscess, continue Oxacillin and  
 19 Ceftriaxone for protracted course. Two,  
 20 leukopenia. Await today's count, last 2.94. May  
 21 improve off Vancomycin, but if continues to fall,  
 22 less than 2.0, may need GCSF to maintain. Three,  
 23 recent fever resolving off Vanco., suspect  
 24 Vancomycin fever. Also, now on low dose Ampho. for  
 25 yeast cystitis, doubt cause of fever though. Hope

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1 will clear with short course, few days. At low  
 2 dose, Ampho. should not be nephrotoxic. Four,  
 3 family issues. Discussed ID issues extensively with  
 4 husband and daughter, gave my card and number.  
 5 Discussed also with Dr. McHenry who will take over  
 6 ID consult service on 11-2-98.  
 7 10-29-98, addendum, understand from Lori Bell,  
 8 social worker, that family meeting has been set up  
 9 for Monday, 11-2, at 11:30. I will try to be there,  
 10 and Dr. McHenry, who will take over the ID consult  
 11 service that day, will definitely be there. I have  
 12 outpatient clinic that a.m., my own and ID fellow's  
 13 patient, but barring emergencies will try to be  
 14 there at 11:30.  
 15 10-30-98, afebrile, says hi, right arm shaking,  
 16 chest clear, COR, no murmur, abdomen soft, plus  
 17 bowel sounds, nontender. Extremities, PAS on, skin  
 18 no rash. Labs, white count up to 4.68, micro recent  
 19 blood cultures negative to date. 10-27 urine  
 20 yeast.  
 21 Impression, one, bacteremic klebsiella MSSA,  
 22 right frontal brain abscess, close to four weeks Rx  
 23 so far, four to six months planned as per Dr.  
 24 Barnett. In other words, he intended a much longer  
 25 course. And then I put appreciated chance to

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1 discuss ID issues in detail with Dr. Barnett today.  
 2 Size of abscess is diminishing as per measurements  
 3 on computerized screen. Her leukopenia is  
 4 improved. Off Vanco. Fever is improved off Vanco.  
 5 Two, check UA CNS to assess clearance of yeast.  
 6 Note, husband not in room tonight when I rounded.  
 7 Q. Do you recall what conversation you had with Dr.  
 8 Barnett as referenced in that note?  
 9 A. I recall that he felt that she would need longer  
 10 therapy than six to eight weeks, that he thought  
 11 that it might need to be continued longer than that,  
 12 and as usual we would measure resolution by how  
 13 things improved on scan, and he stated that he had  
 14 looked at it on the computerized screen and that the  
 15 measurements were improving.  
 16 10-31-98, seen and discussed issues extensively  
 17 with husband. Right arm tremor continues, no fever  
 18 but plus sweats. Frequent bowel movements reported  
 19 but not diarrhea, apparently. Micro C difficile and  
 20 urine are pending, blood cultures times two, 10-27  
 21 negative to date. White blood count 4.68 up.  
 22 10-30, creatinine 0.8.  
 23 Impression, one, MSSA, slash, klebsiella, brain  
 24 abscess, continues on long course of Oxacillin and  
 25 Ceftriaxone. White blood count now up, off Vanco.

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1 Two, fevers were likely Vanco., repeat blood  
 2 cultures negative. Three, yeast UTI, repeat  
 3 pending. Four, frequent bowel movements but not  
 4 diarrhea, agree check C difficile. Five, right arm  
 5 shaking, uncertain of cause but would be unusual  
 6 side effect for these antibiotics. And I put  
 7 re-check liver function tests.  
 8 11-1-98, afebrile, yeast in urine cleared.  
 9 Exam, chest clear, COR, no murmur, two branch  
 10 erythematous lesions right neck and upper chest, did  
 11 not look cellulolytic. Abdomen soft, plus bowel  
 12 sounds, nontender. Extremities, no edema, PAS on.  
 13 Labs, creatinine 0.8, AST 26, ALT 45, alkaline  
 14 phosphatase 75, bilirubin 0.4, white blood count  
 15 7.44. Micro, no new positive cultures. 11-1-98  
 16 urine negative.  
 17 Impression, one, bacteremic brain abscess,  
 18 klebsiella, MSSA. On long-term Oxacillin plus  
 19 Ceftriaxone. Family very focused this p.m. as to  
 20 whether or not she had, quote, unquote, meningitis  
 21 as part of her original presentation. Explained she  
 22 had elevated white cells in the 10-5 CSF at that  
 23 time but CSF culture did not grow. Emphasized that  
 24 the longer term issue is the brain abscess and she's  
 25 been on appropriate therapy for CNS infection all

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1 along. Two, elevated white blood count last two  
 2 days, off Vanco., now normal. I mean, increased  
 3 WBC, not elevated. Three, fungal UTI cleared, D/C  
 4 Ampho. I think this is after one to two days.  
 5 Q. The left-hand margin?  
 6 A. Dr. McHenry takes over ID consult service in a.m.,  
 7 both of us will try to attend family meeting  
 8 tomorrow, family at bedside, daughter is lying in  
 9 bed with mother.  
 10 Q. Having reviewed all your records now, do you have  
 11 any additional independent memories that were  
 12 refreshed that you haven't covered already?  
 13 MS. DISILVIO Other than what she told  
 14 you about the diarrhea?  
 15 MR. LINTON: Correct.  
 16 A. Yeah, well, that last just reminded me that there  
 17 really appeared to be some rather unusual  
 18 interactions between her and her family, but that's  
 19 probably about all I can add.  
 20 Q. In what way were the interactions unusual?  
 21 A. Well, finding the daughter in bed with the mother in  
 22 the hospital bed I would say is a little unusual.  
 23 Q. What was the mother's physical condition at that  
 24 time?  
 25 A. Well, pretty much what we've described. I don't

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1 know that I can add that much to it. I think that  
 2 detailed neuro exams I wasn't doing since I wasn't  
 3 focused on those issues, nor was I really focused on  
 4 her functional capabilities.  
 5 Q. Do you know what time of day you did that consult?  
 6 A. When I came by that day?  
 7 Q. Yeah.  
 8 A. I have no idea.  
 9 Q. Many of the references that you read talk about  
 10 bacteremia, brain abscess or brain abscess,  
 11 bacteremia. You're not suggesting with the order of  
 12 those words that one caused the other, both were  
 13 separate conditions; is that correct?  
 14 A. I'm not suggesting one caused the other, that's  
 15 correct, and oftentimes we're writing these notes in  
 16 a relative hurry. I will have a shorthand for the  
 17 condition we're treating. I like to repeat in each  
 18 note the condition we're treating in case someone is  
 19 coming to the chart fresh, but it doesn't mean that  
 20 reflects my thoughts on the genesis.  
 21 Q. So again, your opinion is you're unsure as to which  
 22 caused which?  
 23 A. Correct.  
 24 Q. Can you now identify, without reading the note, the  
 25 notes that were done by - whether they were done by

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1 a student or a resident, are you able to tell us  
 2 that based on who signed off from the note?  
 3 MS. DISILVIO: The ID notes from the  
 4 very beginning of time?  
 5 Q. Just from --  
 6 A. I can tell which ones.  
 7 Q. Can you tell us who they were?  
 8 A. Oh, you mean who the people were who wrote them?  
 9 Q. Right, whether it was a medical student or a medical  
 10 resident.  
 11 MS. DISILVIO So the record is clear,  
 12 from October 19th until she went off the  
 13 service?  
 14 MR. LINTON: Correct.  
 15 A. Sure, I can do that. I'll start from the beginning  
 16 of 10-19. This Stephanie is the last name, I think  
 17 his first name was Brian, and I believe he was a med  
 18 student at that time, Brian Stephanie. 10-20, this  
 19 is Brian Stephanie again. 10-21, Brian Stephanie.  
 20 10-22 is Brian Stephanie. That's not mine.  
 21 10-25 is a new person on the team, I believe,  
 22 and I think, yeah, this is Dr. Seshadri,  
 23 S-E-S-H-A-D-R-I, and he is -- he was a medical  
 24 resident, and I don't recall his first name. 10-26  
 25 is Dr. Seshadri. There must have been a change of

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1 service for the residents at that time. 10-27 is  
 2 Dr. Seshadri. 10-28, Dr. Seshadri. 10-29, Dr.  
 3 Seshadri. 10-30, Dr. Seshadri. 11-1, Dr.  
 4 Seshadri. And that ended my tour of duty. Dr.  
 5 McHenry came on on 11-2.  
 6 Q. We'll attach this as Exhibit 1 to your deposition,  
 7 your CV. I take it that's your most recent one?  
 8 A. Correct.  
 9 Q. Are there any articles that you have authored or  
 10 assisted in authoring that relate to the issues in  
 11 this case?  
 12 A. No.  
 13 MR. LINTON: Give us just a minute, if  
 14 you would.  
 15 - - -  
 16 (Thereupon, Plaintiffs' Avery Exhibit 1  
 17 was mark'd for purposes of identification.)  
 18 - - -  
 19 (Thereupon, a discussion was had off  
 20 the record.)  
 21 - - -  
 22 Q. I want to make sure that you have now covered all  
 23 discussions that you can remember that you had with  
 24 this family.  
 25 A. Let me think one more time.

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1 Q. Sure. Take as much time as you need.  
 2 A. I do recall conversations on one other topic, which  
 3 was they asked me repeatedly what I thought the  
 4 extent of her neurologic recovery would be and what  
 5 would be the time course of that recovery.  
 6 Unfortunately, I really couldn't answer that very  
 7 well, because it's highly variable from one person  
 8 to another. Other than that, I think that was about  
 9 it.  
 10 Q. What deficits did she have as a result of the  
 11 infection?  
 12 A. Well, I did not do detailed neurologic testing on  
 13 her, as you know. As I recall, she had very little  
 14 verbal output, she did not always follow commands,  
 15 and she moved her right side more than her left  
 16 side, but beyond that I could not be more specific.  
 17 Q. Have we now covered all the conversations you can  
 18 recall having with the family?  
 19 A. Yes.  
 20 Q. In your entire time here at the Cleveland Clinic,  
 21 can you recall any other postoperative infection  
 22 that cultured a klebsiella oxytoca?  
 23 A. Oh, I am sure I have seen it. It's not totally  
 24 uncommon, but I can't recall the specific  
 25 circumstances.

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1 Q. Have you ever seen it in any other neurosurgical  
 2 case?  
 3 A. You know, I really couldn't be sure. As I said, I'd  
 4 have to go back and look at my records.  
 5 Q. How about a combination staph and klebsiella  
 6 oxytoca?  
 7 A. We do occasionally see polymicrobial infections,  
 8 meaning more than one bug, and that particular  
 9 combination I know I've seen before.  
 10 Q. Following surgery?  
 11 A. I can't recall the details, but I know that  
 12 combination has occurred before in patients that  
 13 I've seen.  
 14 Q. As you sit here can you recall a single other  
 15 operation that led to an infection with both those  
 16 organisms?  
 17 A. I can't recall any details, but that's not an  
 18 unheard of combination.  
 19 Q. The abscess was on the right side of the brain?  
 20 A. The right frontal lobe, correct.  
 21 Q. And the cultured positive wound was actually on the  
 22 left side, correct?  
 23 A. Correct.  
 24 Q. Assuming that it was the brain abscess that then led  
 25 to the wound site infection, why is it that it goes

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1 to the left side as opposed to the right side?  
 2 MS. DISILVIO: Objection. You may  
 3 answer.  
 4 A. That's okay. It's an interesting question and  
 5 actually in reviewing the records today I noted from  
 6 Dr. Rehm's notes and the notes at the time that  
 7 initially the left side drained and then they  
 8 mentioned the left side relatively dried up and then  
 9 the right side began to drain and for some days the  
 10 right side was far more purulent.  
 11 Now, my understanding of the stereotactics,  
 12 again, I don't know that much about it, but I  
 13 believe that they are going in and meeting at a  
 14 similar point, so for one reason or another, the  
 15 left side was the first to be involved, the right  
 16 side was wound manifested later. Whether that had  
 17 to do with the brain abscess being primary and  
 18 draining first out one side or the other, or whether  
 19 it started on the left wound side then became a  
 20 brain abscess which subsequently drained out the  
 21 right side, or whether it started at some other  
 22 source, again, I cannot say.  
 23 Q. So the fact that it may have started on the right  
 24 side in the brain would not rule out it going to the  
 25 left side and then the right side of the brain?

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1 A. Correct, because if the brain abscess were primary,  
 2 pus drains, it likes to drain, it takes the path of  
 3 least resistance. So if the left sided tracts were  
 4 easier for it to pass through, I suppose it could  
 5 cross sides, but again, I can't express any strong  
 6 opinion on that.  
 7 Q. You'd be speculating either way?  
 8 A. Highly speculating, yes.  
 9 Q. Let me ask you this, we got into a discussion  
 10 earlier about the --starting to ask about the  
 11 source of the infection and then you said about the  
 12 onset of the infection. Based on your review of the  
 13 chart, what was the first noted onset of an  
 14 infection or symptoms related to an infection?  
 15 A. Again, I did not see her at that time.  
 16 Q. I assume --  
 17 A. But the major event seems to have been on or around  
 18 the 4th or shortly before that when she spiked a 39  
 19 and the purulent drainage from the wound was noted.  
 20 Q. This likely would be the last time I get to talk to  
 21 you before this case goes to trial and I just want  
 22 to make sure I cover with you any opinions that you  
 23 have in this case. Are there any opinions that you  
 24 hold with a reasonable medical probability that  
 25 you've not expressed to this point in this case?

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1 MS. DISILVIO: About --  
 2 Q. About anything related to Mary Lou Zimmerman.  
 3 A. Not that I can recall.  
 4 MR. LINTON: Okay. Thank you very  
 5 much.  
 6 MS. DISILVIO: We'll read it. If you  
 7 could send one copy to the doctor here, one  
 8 copy to me, and I'll have her tell you her  
 9 mailing address. And, Doctor, if it's ordered,  
 10 and I suspect your transcript will be ordered,  
 11 it will come in a little booklet form. I know  
 12 Laura has taken down everything perfectly, but  
 13 you have the opportunity to read it and to make  
 14 any corrections that need to be made to maybe  
 15 spellings or as we went through the progress  
 16 notes we went through it rather quickly, so  
 17 you'll have the opportunity to read it and make  
 18 any corrections that are needed, and that's  
 19 what we'll do.

ROBIN K. AVERY, M.D.

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## CERTIFICATE

The State of Ohio ) SS:  
 County of Cuyahoga.)

I, Laura L. Ware, a Notary Public within and  
 for the State of Ohio, do hereby certify that the  
 within named witness, ROBIN K. AVERY, M.D., was by  
 me first duly sworn to testify the truth, the whole  
 truth, and nothing but the truth in the cause  
 aforesaid; that the testimony then given was reduced  
 by me to stenotype in the presence of said witness,  
 subsequently transcribed into typewriting 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 27th day of September, 2000.

  
 Laura L. Ware, Ware Reporting Service  
 21860 Crossbeam Lane, Rocky River, Ohio 44116  
 My commission expires May 17, 2003.



1 MS. DISILVIO: About --

2 Q. About anything related to Mary Lou Zimmerman.

3 A. Not that I can recall.

4 MR. LINTON: Okay. Thank you very  
5 much.

6 MS. DISILVIO: We'll read it. If you  
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19 what we'll do.

20

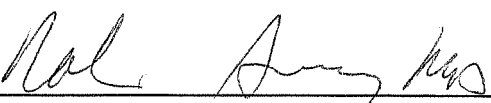
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ROBIN K. AVERY, M.D.

Case Title: MARY LOU ZIMMERMAN VS. CLEVELAND CLINIC

Case Number: 399411 Deposition Date: 9/11/00

I, ROBIN K. AVERY MD, wish to make the following changes:

PAGE	LINE	CHANGE:
<u>44</u>	<u>4</u>	<u>"we're at approximately" should be</u> <u>"we plan approximately"</u>
<u>47</u>	<u>22</u>	<u>"diagram stain" should be</u> <u>"Gram stain"</u>
<u>50</u>	<u>8</u>	<u>"or gram negative cultures"</u> <u>should be "For Gram-negative</u> <u>coverage"</u>
<u>51</u>	<u>12</u>	<u>CHANGE: "138.4" should be "38.4"</u>
<u>54</u>	<u>9</u>	<u>CHANGE: "branch" should be "blanching"</u>
<u>54</u>	<u>11</u>	<u>CHANGE: "cellulolytase" should be</u> <u>"cellulite"</u>
<u>57</u>	<u>16, 18, 19, 20</u>	<u>CHANGE: "Stephanie" should be</u> <u>"Stephany"</u>
<u>    </u>	<u>    </u>	<u>CHANGE: _____</u>
<u>    </u>	<u>    </u>	<u>CHANGE: _____</u>
<u>    </u>	<u>    </u>	<u>CHANGE: _____</u>
<u>    </u>	<u>    </u>	<u>CHANGE: _____</u>

I have read my deposition, and having made the corrections that I wish to make hereby  
affix my signature.

Signature: Robin K. Avery MD Date: 10/17/00

***Ware Reporting Service***  
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October 18, 2000

Robert F. Linton, Jr., Esq.  
Linton & Hirshman  
Hoyt Block Building - Suite 300  
700 West St. Clair Avenue  
Cleveland, Ohio 44113


Re: **Mary Lou Zimmerman, et al. vs. The Cleveland Clinic Foundation**  
Cuyahoga Common Pleas, Case No., 399411  
Deposition: Robin K. Avery, M.D., taken 9-11-00

Dear Bob:

Enclosed please find the errata sheet(s) and signature page signed by Dr. Avery regarding the above-captioned case.

If you have any questions, please do not hesitate to call.

Sincerely,

  
Laura L. Ware

LLW/nh

Enclosures

cc: Marilena DiSilvio, Esq.



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## Z

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**PLAINTIFF'S  
EXHIBIT**

1 Avery  
9-11-00 lw

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**EDUCATION**

B.A. 1980 Harvard-Radcliffe College, summa cum laude (Philosophy)  
M.D. 1985 Harvard Medical School, cum laude

**POSTDOCTORAL TRAINING**

1985-88 Medical Internship, Junior and Senior Residency in Internal  
Medicine, Massachusetts General Hospital (Senior Residency  
in the Primary Care Program)  
  
1989-1993 Infectious Disease Fellowship, Massachusetts General Hospital

**LICENSURE AND CERTIFICATION**

1988 Massachusetts Medical License #58099  
1993 Ohio License #65151  
1988 Internal Medicine Board Certification  
1992 Infectious Disease Board Certification (Passed in 99th percentile)

**ACADEMIC AND HOSPITAL APPOINTMENTS**

1988-89 Staff Physician, Boston Health Care for the Homeless Program;  
concomitant staff appointment, Boston City Hospital  
  
1989-90 Clinical Fellow in Infectious Disease, Massachusetts General  
Hospital  
  
1990-1993 Clinical and Research Fellow in Infectious Disease,  
Massachusetts General Hospital

1993- Staff Physician, Department of Infectious Disease, Cleveland Clinic Foundation

### **COMMITTEES**

General Medical Research Programs Committee, Cleveland Clinic Foundation  
Transplant Executive Committee, Cleveland Clinic Foundation  
Bone Marrow/Infectious Disease Study Group, Cleveland Clinic Foundation

### **AWARDS AND HONORS**

1978	Radcliffe Centennial Scholar
1979	Phi Beta Kappa
1979,80	Lucy Allen Paton Prizes, Radcliffe College, for the Humanities
1980	Edwin deT. Bechtel Thesis Prize in Philosophy, Harvard College
1980,81	Rotary Fellowship for study in Tokyo, Japan
1984	Albert Schweitzer Fellowship for medical work in Lambarene, Gabon
1985	Dr. Sirjay Sanger Award for Psychiatry Essay, Harvard Medical School
1989	Boston City Hospital House Staff "Golden Guaiac Award"
1991	Edward H. Kass Award for Clinical Excellence. Massachusetts Infectious Diseases Society
1997	Bruce Hubbard Stewart Fellow, Cleveland Clinic Foundation

### **TEACHING EXPERIENCE**

1986	Nominated for a Harvard Medical School Teaching Award as a resident
1988-89	Coordinated teaching sessions for staff of Boston Health Care for the Homeless Program
1989	Sessions in antibiotic management for Medicine Core Clerkship students, Massachusetts General Hospital
1992,93	Lab instructor, HMS-II Pathophysiology of Infectious Disease Course, Harvard Medical School (Received highest evaluation of instructors in that course, 1992)
1993 on	Teaching of fellows, residents, and medical students at Cleveland Clinic

### **GRANTS AND SUPPORT**

1990-93	American Cancer Society Postdoctoral Fellowship #PF-3488 for the project, "Cytolytic Hybridomas and Resistance to Lysis." (Mentor: Dr. Mark Pasternack, Infectious Disease Unit, Massachusetts General Hospital.)
---------	---

## ONGOING PROTOCOLS

1. RPC #4742 -"A Pilot Trial to Evaluate the Pharmacokinetics. Safety and Efficacy of a Liquid and Virally Inactivated Formulation of Cytomegalovirus Immune Globulin (CMVIG) combined with Ganciclovir in Liver Transplant Recipients at risk for Primary Infection:  
STATUS: Multicenter Trial (Dr. David Snyderman NEMC). Study completed; data analysis in progress
2. IRB#1090- Avery R, et al "A Randomized Controlled Comparison of Ciprofloxacin plus Single Daily Dose Vancomycin and Tobramycin for Empiric Therapy of Fever in Neutropenic Recipients of Autologous Bone Marrow Transplants."  
STATUS: Study completed; data analysis in progress. Abstracts presented ASTP 5/97.
3. Avery R. Randomized trial of intermittent intravenous versus oral ganciclovir after initial intravenous ganciclovir for prevention of CMV infection in lung transplant recipients. Submitted to Roche Pharmaceuticals for consideration of study.
4. IRB#1609-Avery R, et al: A Randomized Controlled Trial of Short-Course versus Indefinite Single-daily dose Vancomycin in Conjunction with Ticarcillin-clavulanate and Single-Daily Dose Gentamicin for the Empiric Treatment of Neutropenic Fever in Autologous Peripheral Blood Progenitor Cell Transplant Recipients. Status: Currently enrolling patients.

## ABSTRACTS

1. Avery R, McCarthy P, Mossad S. Goormastic M, Bott-Silverman C, Hobbs R, James K, Rincon G, Pelegrin D, Waldmann T, Stewart R. Cytomegalovirus prophylaxis with ganciclovir after heart transplantation. Poster presentation, American Society of Transplant Physicians, 15<sup>th</sup> Annual Meeting, May 1996.
2. Braun **W**, Avery R, et al : Infections in patients with long-term functioning renal allografts, Oral presentation, International Transplant Meeting, Barcelona, 8/96.
3. Husni R. Gordon S, Quereshi M, Arroliga A, Haug M, Kirby T, Avery R, Longworth D. Risk factors for invasive aspergillosis in lung transplant recipients. Abstract IDSA 34th Annual Meeting 1996.
4. Kathawalla SA, Stillwell PC, Gordon S, Haug M, Perl M, Arroliga AC, Mehta AC, Avery R, Kirby T. Cytomegalovirus infection in seromismatched lung transplant recipients with and without prophylaxis with CMV immunoglobulin, Presented, Lung Transplant meeting, 1995. Transplantation Proceedings 28:(suppl 2); 16, 1996

5. LaRosa S, Gordon S, Kalmadi **S**, Truesdell L, Avery R, Arroliga A, Longworth D. Should prophylaxis for *Pneumocystis carinii* pneumonia in solid organ transplant recipients ever be discontinued? Presented, IDSA 34<sup>th</sup> Annual Meeting.
6. Nasser R, Hajjar I, Sandhaus **S**, Hall G, Washington **J**, Bolwell R, Avery R, Longworth **D**, Adal **K**. Routine cultures of bone marrow and peripheral stem cell harvests: clinical impact and cost analysis. Presented, IDSA 34<sup>th</sup> Annual Meeting.
7. Snyderman D, Avery **R**, Perlino C, Freeman R, Rohrer R, Fairchild R, Crowley M, Falagas M, O'Rourke E, and CMVIG Study Group. Combination cytomegalovirus immune globulin (CMVIG) plus ganciclovir (GCV) prophylaxis for CMV seronegative liver transplant recipients (R-) of a CMV seropositive donor organ (D+): preliminary analysis of an open-label study. Abstract, submitted for International Transplant meeting, 8/96.
8. Avery RK: The disproportionate burden of CMV in lung transplant recipients. Oral presentation, Abstract #285, 16th Annual Meeting, American Society of Transplant Physicians, 1997.
9. Avery R, Longworth D, Pohlman B, et al: Prophylaxis of invasive aspergillosis with itraconazole in allogeneic bone marrow transplant recipients; Preliminary results. Poster presentation, ASTP, 1997, Abstract #531.
10. Avery RK, et al : The yield of blood cultures in febrile autologous peripheral blood progenitor cell transplant recipients. Poster presentation, ASTP 1997, Abstract #532.
11. Avery R, Pohlman B, Longworth D et al: A randomized prospective trial of single daily dose vancomycin and tobramycin plus oral ciprofloxacin versus standard triple antibiotics in febrile neutropenic recipients of autologous progenitor cell transplants. Poster presentation, ASTP, 1997, Abstract #530.
12. Avery R, Pohlman B, Adal **K**. et al: High prevalence of diarrhea but infrequency of documented C. difficile in autologous peripheral blood progenitor cell transplant recipients. Poster presentation, ASTP, 1997, Abstract #533.
13. Avery R, Mossad **S**, Pelegri D et al: Prophylaxis of primary cytomegalovirus infection and disease after heart transplantation: does adding cytomegalovirus immune globulin to ganciclovir help? Oral presentation, ASTP 1997, Abstract #282.
14. Avery R, Brakeman J, Adal **K**. Henderson JM Bolwell B, Longworth D et al: Infectious outcomes in transplantation in international patients. Poster presentation, IDSA 35th Annual Meeting, 1997.

## BLIOGRAPHY

1. Raba JM, Joseph H, Avery RK et al. (1990) Homelessness and AIDS. In Under the Safety Net: The Health and Social Welfare of the Homeless in the United States, eds. P.W. Brickner et al, W.W. Norton, New York/London.  
  
(The above book received the World Hunger Year's World Hunger Media Award for Best Book for 1990)
2. Avery RK (1991). AIDS and HIV Infection. In The Manual of Common Communicable Diseases in Shelters, eds. James J. O'Connell and Janet Groth, Boston Health Care for the Homeless Program.
3. Avery RK, O'Connell JJ (1992). Human Immunodeficiency Virus and Homeless Persons. In Deliverina Health Care to Homeless Persons, eds. David Wood. Springer Publishing Company.
4. Avery RK, Bleier KJ, Pasternack MS (1992). Differences between ATP-mediated cytotoxicity and cell-mediated cytotoxicity. J Immunol, August, 1992.
5. Avery RK, Baker AS. Chlamydial infection. In Principles and Practice of Ophthalmology, eds. Daniel M. Albert and Frederick A. Jakobiec, W.B. Saunders, 1994.
6. Avery RK, Madoff S, Zartman G, Baker AS: Mycoplasma hominis wound infection. Infect Dis Clin Pract, 1994;3(1):32-34.
7. Avery RK : infections and immunizations in organ transplant recipients: a preventive approach. Cleveland Clinic J Med 1994;61(5):386-392.
8. Avery RK, Salrnan S, Baker AS: Rhinoscleroma treated with ciprofloxacin: a case report. The Laryngoscope, 105:1-3, July 1995.
9. Avery RK, Longworth DL: Viral pulmonary infections in thoracic and cardiovascular surgery. Semin Thorac Cardiovasc Surg 1995;7:88-94.
10. Wagner L, Avery RK, Bensinger L, Kusnitz F, Hibberd PL, Pasternack MS: Inhibition of cytotoxic T lymphocyte-triggered apoptosis by target cell surface-coupled aprotinin. Mol Immunol 1995, 32(12):853-864.
11. Avery RK, Pasternack MS: Approach to the adult patient with recurrent infections. Cleveland Clinic J Med 1997, 64(5):249-257.
12. Mayes JT, O'Connor BJ, Avery R et al: Transmission of Toxoplasma aondii infection by liver transplantation. Clin Infect Dis 21:511-5, 1995.



13. Dodds EM, Lowder CY, Foster RE, Avery RK, Prayson RA. Serous retinal detachments in a patient with clinically resistant cytomegalovirus retinitis. Archives of Ophthalmology. 1996 July; 114(7):896-897.
14. Avery RK, McCarthy P, Mossad S et al: CMV Prophylaxis in heart transplant recipients. In preparation.
15. Charles R, Brzezinski A, Avery RK, et al: Case report. Disseminated cytomegalovirus infection presenting as Crohn's disease with pyoderma gangrenosum In preparation.
16. Levin L. Avery RK, Shore J. Woog, J, Baker AS. The spectrum of orbital aspergillosis. Survey of Ophthalmology, 1996, 41 :142-54.
17. Avery RK, Eavey RD, Torre TD, Ramos D, Pasternack MS. Bilateral otitis media and mastoiditis caused by a highly resistant strain of Mycobacterium chelonae. Pediatric Infectious Disease Journal 1996 Nov;15(11):1037-1040.
18. Kathawalla SA, Stillwell PC, Gordon S, Haug M, Perl M, Arroliga AC, Metha AC, Avery R, Kirby T. Cytomegalovirus infection in seromismatched lung transplant recipients with and without prophylaxis with CMV immunoglobulin. Transplant Proc 1996 Dec;28(6 Suppl 2):16.
19. Avery RK, Brakeman J, Adal K, Bolwell B, Henderson JM, Novick A, Longworth DL. infections in international transplant recipients. To be submitted to Transplantation
20. Avery RK, Barnes D, Teran J et al: Listeria monocytogenes tricuspid valve endocarditis with septic pulmonary emboli in a liver transplant recipient. Transplant Infectious Disease 1999 Dec;1(4):284-287.
21. Mossad S. Avery RK, Goormastic M, Hobbs RE, Stewart R, Significance of positive cultures from donor left atrium and post-preservation fluid in heart transplantation. Submitted to Transplantation.
22. Braun WE, Avery RK, Gifford RW Jr, Straffon RA. Life after 20 years with a kidney transplant: redefined disease profiles and an emerging nondiabetic vasculopathy. Transplant Proc 1997;29:247-249.
23. Muruve NA, Novick AC, Goldfarb DA, Flechner S, Dennis V, Avery R, Hodge EE. Risk factors, management, and outcome in renal transplant recipients experiencing CMV infections. (Submitted to Transplantation).
24. Avery RK. Transplant infectious disease: messages for the generalist. (submitted to CCJM)

25. Husni R, Northington D, Goldman M, Camisa C, Avery RK. Severe cutaneous reactions to vancomycin: report of three cases and review of the literature. (To be submitted).
26. Nasser RM, Hajjar I, Sandhaus L, Bolwell BM, Avery RK, Longworth DL, Hall GS, Adal KA. Routine cultures of Bone Marrow and Peripheral Stem All Harvests: Clinical impact, cost analysis, and review of the literature. Submitted for publication.
27. Khan A, Lytle B, Taylor P, Longworth DL, Dorosti K, Walsh M, Avery RK. The spectrum of highly symptomatic cytomegalovirus infection after non-transplant cardiac surgery. (To be submitted).
28. Avery RK, Baker AS. Chlamydial Disease. Chapter 250 (revision for 1997 edition): Principles and Practice of Ophthalmology, Second Edition, WB Saunders.
29. Helm TN, Avery RK, Tomecki KJ. Respiratory dimorphic fungal infections. In Toxins in Clinical Dermatology, et. Boni E. Elewski, 1997.
30. LaRosa S, Gordon S, et al. Should prophylaxis for Pneumocystis carinii pneumonia in solid organ transplant recipients ever be discontinued? Submitted for publication.
31. Husni R, Gordon SM, Longworth DL, Arroliga A, Stillwell P, Avery RK, Maurer JR, Mehta A, Kirby T. Cytomegalovirus infection is a risk factor for invasive aspergillosis in lung transplant recipients. Submitted for publication.
32. Avery, RK, Prevention and treatment of cytomegalovirus infection and disease in heart transplant recipients. Current Opinion in Cardiology, 1988 Vol. 13:122-129.
33. Dumot JA, Barnes DS, Younossi Z, Gordon SM, Avery RK, Domen RE, Henderon M, Carey WD: Immunogenicity of hepatitis A vaccine in decompensated liver disease. American J of Gastroenterology, 1999 Vol 94:1601-1604.
34. Mossad, SB, Tomford, JW, Avery, RK, Hussein, MA, Vaughn, KW: Isolated Primary Hepatic Lymphoma in a Patient with Acquired Immunodeficiency Syndrome. International Journal of Infectious Diseases, 1999 Vol 4 Number 1: 57-58.
35. Avery RK, Pohlman B, Adal K, Bolwell B, Goldman M, Kalaycio M, Hall G, Andresen S, Mossad S, Schmitt S, Mason P, Longworth D. High prevalence of diarrhea but infrequency of documented *Clostridium difficile* in autologous peripheral blood progenitor cell transplant recipients. Bone Marrow Transplantation, 2000 Vol. 25: 67-69.

#### **OTHER PROJECTS IN PROGRESS**

1. Retrospective review of infections in allograft BMT recipients. Cleveland Clinic Foundation 1992-95. 1. CMV prophylaxis. 2. Utility of BAL and open lung

- biopsy. 3. Infections in sulfa-intolerant patients.
2. Infectious complications in long term (15-20 year) recipients of renal transplants (with W. Braun, M.D.)
  3. Hypogammaglobulinemia in lung transplant recipients. With Dr. N. Goldfarb and Dr. J. Maurer.

### **GRAND ROUNDS PRESENTATIONS**

**10-14-93** Medical Grand Rounds, Cleveland Clinic Foundation (with Dr. Steven Gordon) "New and Emerging Infectious Disease Pathogens in the 1990's."

### **OTHER TALKS**

October 20-21, 1993	"Infections and Immunization in the Renal Transplant Patient." Nephrology Update. Cleveland Clinic Foundation.
November 15, 1993	"Infections and Immunization in the Renal Transplant Patient." American Society of Nephrology Boston, Massachusetts
December 22, 1993	infectious Disease Grand Rounds, Cleveland Clinic Foundation. "Infectious Diseases and the Skin".
January 18, 1994	"Infectious in the Immunocompromised Host", Cleveland Clinic Foundation.
February 9, 1994	"What's New in Transplant ID". Infectious Disease Grand Rounds, Cleveland Clinic Foundation
1994-1995	"Liver Disease After Transplantation". Infectious Disease Grand Rounds, Cleveland Clinic Foundation.
	"Role of Superantigens in Disease Causation." Infectious Disease Grand Rounds. Cleveland Clinic Foundation
September, 1995	"Reconstitution of the Immune System after Bone Marrow Transplant". Infectious Disease Grand Rounds, Cleveland Clinic Foundation.
January 24, 1996	"Unusual Causes of Lymphadenopathy". Infectious Disease Grand Rounds, Cleveland Clinic Foundation.
March 1996	Workshop: Medical Management of Renal Transplant Patients,

With Drs. W. Braun, D. Goldfarb and B. Brouhard, Nephrology Update 1996.

- May 1996                      American Society of Transplant Physicians. Luncheon Workshop, Post-Transplant Infections, with Dr. Robert Rubin.
- June 1996                    "Infections in the Immunocompromised Host", Cleveland Clinic Eighth Annual Intensive Review of Internal Medicine.
- August 1996                Martin C. McHenry Symposium; "Transplant infectious Disease for the Generalist."
- Nov. 1996                    Medical House Staff Conference "Infections in the Immunocompromised patient."
- March 5, 1997              Infectious Disease Grand Rounds: infections in Autologous Bone Marrow Transplant Recipients: Research Update. Cleveland Clinic Foundation.
- March 12, 1997             "Infectious complications in recipients of Autologous Peripheral Stem Cell Transplants, Medical College of Ohio.
- March 19, 1997            Nephrology Update 1997 Workshop: Medical Management of the Renal Transplant Patient
- May 22, 1997               Tick-Borne Diseases. In "2nd Annual May Day Therapy: Dermatology", Cleveland Clinic Foundation.
- June 3, 1997                Lung Transplantation: Infections and You. Second Wind Lung Transplant Support Group.
- October 27, 1997            Talk to Skin Care Team; "skin Infections"
- November 4, 1997           Medical House Staff. Noon conference. "Infections in the Immunocompromised Host."
- November 3, 1998           I.D. Subspecialty Conference at Fairview Hospital: "Infections In Renal Transplant Patients
- November 2, 1999           I.D. Conference at Fairview Hospital: "Granulocytopenia, immuno Comp Host and Infections."

#### **INTRA-DEPARTMENTAL TEACHING**

Monthly Transplant ID Lunch conference (case presentations, discussions, with Dr. Sherif Mossad).

Extensive teaching of fellows, residents, and students on ID inpatient consult service (12 weeks/year), primary service (4 weeks/year), Bone Marrow service and Outpatient Modules (rest of year.)

#### **OUTSIDE MEDICAL ACTIVITIES**

Cleveland Health Care for the Homeless: Wednesday afternoon clinics at Payne Avenue Clinic and Monday evening clinics at City Mission (volunteer service). Providing direct care (general internal medicine) to homeless patients with a wide variety of conditions; supervising and teaching nurses in the Homeless Program and rotating CCF primary care residents.

#### **PROFESSIONAL SOCIETIES AND COMMITTEES**

American Society of Transplant Physicians, Member 1997 (ASTP)

Post Transplant Infections Committee

Visiting Faculty Program, "Progress in Prevention of CMV Disease in Solid Organ Transplantation," Sponsored by Tufts University (1997)

Viral Hepatitis Clinical Guidelines Committee, Cleveland Clinic Foundation (1997)

# ***Ware Reporting Service***

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September 28, 2000

Robin K. Avery, M.D.  
The Cleveland Clinic Foundation  
9500 Euclid Avenue, Desk S32  
Cleveland, Ohio 44195

Re: **Mary Lou Zimmerman, et al. vs. The Cleveland Clinic Foundation**  
Cuyahoga Common Pleas, Case No. 399411

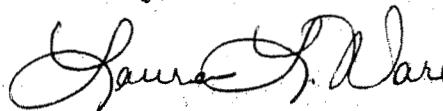
Dear Dr. Avery:

Enclosed please find your deposition which was taken on September 11, 2000. **Once you have read and signed the last page of your deposition and made any corrections on the errata sheet(s) provided, please mail the entire transcript along with the errata sheet(s) in the self-addressed envelope enclosed.**

According to the Ohio Rules of Civil Procedure you have 7 days within which to sign the transcript, unless otherwise agreed to by Counsel, or your signature will be deemed waived.

If you have any questions, please feel free to call.

Sincerely,



Laura L. Ware

Enclosures

c: Robert F. Linton, Esq./Mark W. Ruf, Esq.  
Marilena DiSilvio, Esq.

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**EDUCATION**

B.A. 1980 Harvard-Radcliffe College, summa cum laude (Philosophy)  
M.D. 1985 Harvard Medical School, cum laude

**POSTDOCTORAL TRAINING**

1985-88 Medical Internship, Junior and Senior Residency in Internal  
Medicine, Massachusetts General Hospital (Senior Residency  
in the Primary Care Program)

1989-1993 Infectious Disease Fellowship, Massachusetts General Hospital

**LICENSURE AND CERTIFICATION**

1988 Massachusetts Medical License #58099  
1993 Ohio License #65151  
1988 Internal Medicine Board Certification  
1992 Infectious Disease Board Certification (Passed in 99th percentile)

**ACADEMIC AND HOSPITAL APPOINTMENTS**

1988-89 Staff Physician, Boston Health Care for the Homeless Program;  
concomitant staff appointment, Boston City Hospital

1989-90 Clinical Fellow in Infectious Disease, Massachusetts General  
Hospital

1990-1993 Clinical and Research Fellow in Infectious Disease,  
Massachusetts General Hospital

1993- Staff Physician, Department of Infectious Disease, Cleveland Clinic Foundation

### **COMMITTEES**

General Medical Research Programs Committee, Cleveland Clinic Foundation  
Transplant Executive Committee, Cleveland Clinic Foundation  
Bone Marrow/Infectious Disease Study Group, Cleveland Clinic Foundation

### **AWARDS AND HONORS**

1978	Radcliffe Centennial Scholar
1979	Phi Beta Kappa
1979,80	Lucy Allen Paton Prizes, Radcliffe College, for the Humanities
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1980,81	Rotary Fellowship for study in Tokyo, Japan
1984	Albert Schweitzer Fellowship for medical work in Lambarene, Gabon
1985	Dr. Sirjay Sanger Award for Psychiatry Essay, Harvard Medical School
1989	Boston City Hospital House Staff "Golden Guaiac Award"
1991	Edward H. Kass Award for Clinical Excellence. Massachusetts Infectious Diseases Society
1997	Bruce Hubbard Stewart Fellow, Cleveland Clinic Foundation

### **TEACHING EXPERIENCE**

1986	Nominated for a Harvard Medical School Teaching Award as a resident
1988-89	Coordinated teaching sessions for staff of Boston Health Care for the Homeless Program
1989	Sessions in antibiotic management for Medicine Core Clerkship students, Massachusetts General Hospital
1992,93	Lab instructor, HMS-II Pathophysiology of Infectious Disease Course, Harvard Medical School (Received highest evaluation of instructors in that course, 1992)
1993 on	Teaching of fellows, residents, and medical students at Cleveland Clinic

### **GRANTS AND SUPPORT**

1990-93	American Cancer Society Postdoctoral Fellowship #PF-3488 for the project, "Cytolytic Hybridomas and Resistance to Lysis." (Mentor: Dr. Mark Pasternack, Infectious Disease Unit, Massachusetts General Hospital.)
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## ONGOING PROTOCOLS

1. RPC #4742 - "A Pilot Trial to Evaluate the Pharmacokinetics. Safety and Efficacy of a Liquid and Virally Inactivated Formulation of Cytomegalovirus Immune Globulin (CMVIG) combined with Ganciclovir in Liver Transplant Recipients at risk **for** Primary Infection:  
STATUS: Multicenter Trial (Dr. David Snyderman NEMC). Study completed; data analysis in progress
2. IRB#1090- Avery R, et al "A Randomized Controlled Comparison of Ciprofloxacin plus Single Daily Dose Vancomycin and Tobramycin for Empiric Therapy of Fever in Neutropenic Recipients of Autologous Bone Marrow Transplants."  
STATUS: Study completed; data analysis in progress. Abstracts presented ASTP 5/97.
3. Avery R. Randomized trial of intermittent intravenous versus oral ganciclovir after initial intravenous ganciclovir for prevention of CMV infection in lung transplant recipients. Submitted to Roche Pharmaceuticals for consideration of study.
4. IRB#1609-Avery R, et al: A Randomized Controlled Trial of Short-Course versus Indefinite Single-daily dose Vancomycin in Conjunction with Ticarcillin-clavulanate and Single-Daily Dose Gentamicin for the Empiric Treatment of Neutropenic Fever in Autologous Peripheral Blood Progenitor Cell Transplant Recipients. Status: Currently enrolling patients.

## ABSTRACTS

1. Avery R, McCarthy P, Mossad S, Goormastic M, Bott-Silverman C, Hobbs R, James K, Rincon G, Pelegri D, Waldmann T, Stewart R. Cytomegalovirus prophylaxis with ganciclovir after heart transplantation. Poster presentation, American Society of Transplant Physicians, 15<sup>th</sup> Annual Meeting, May 1996.
2. Braun W, Avery R, et al : Infections in patients with long-term functioning renal allografts, Oral presentation, International Transplant Meeting, Barcelona, 8/96.
3. Husni R, Gordon S, Quereshi M, Arroliga A, Haug M, Kirby T, Avery R, Longworth D. Risk factors for invasive aspergillosis in lung transplant recipients. Abstract IDSA 34th Annual Meeting 1996.
4. Kathawalla SA, Stillwell PC, Gordon S, Haug M, Perl M, Arroliga AC, Mehta AC, Avery R, Kirby T. Cytomegalovirus infection in seromismatched lung transplant recipients with and without prophylaxis with CMV immunoglobulin, Presented, Lung Transplant meeting, 1995. Transplantation Proceedings 28:(suppl 2); 16, 1996

5. LaRosa S, Gordon S, Kalmadi S, Truesdell L, Avery R, Arroliga A, Longworth D. Should prophylaxis for *Pneumocystis carinii* pneumonia in solid organ transplant recipients ever be discontinued? Presented, IDSA 34<sup>th</sup> Annual Meeting.
6. Nasser R, Hajjar I, Sandhaus S, Hall G, Washington J, Bolwell R, Avery R, Longworth D, Adal K. Routine cultures of bone marrow and peripheral stem cell harvests: clinical impact and cost analysis. Presented, IDSA 34<sup>th</sup> Annual Meeting.
7. Snyderman D, Avery R, Perlino C, Freeman R, Rohrer R, Fairchild R, Crowley M, Falagas M, O'Rourke E, and CMVIG Study Group. Combination cytomegalovirus immune globulin (CMVIG) plus ganciclovir (GCV) prophylaxis for CMV seronegative liver transplant recipients (R-) of a CMV seropositive donor organ (D+): preliminary analysis of an open-label study. Abstract, submitted for International Transplant meeting, 8/96.
8. Avery RK: The disproportionate burden of CMV in lung transplant recipients. Oral presentation, Abstract #285, 16th Annual Meeting, American Society of Transplant Physicians, 1997.
9. Avery R, Longworth D, Pohlman B, et al: Prophylaxis of invasive aspergillosis with itraconazole in allogeneic bone marrow transplant recipients; Preliminary results. Poster presentation, ASTP, 1997, Abstract #531.
10. Avery RK, et al : The yield of blood cultures in febrile autologous peripheral blood progenitor cell transplant recipients. Poster presentation, ASTP 1997, Abstract #532.
11. Avery R, Pohlman B, Longworth D et al: A randomized prospective trial of single daily dose vancomycin and tobramycin plus oral ciprofloxacin versus standard triple antibiotics in febrile neutropenic recipients of autologous progenitor cell transplants. Poster presentation, ASTP, 1997, Abstract #530.
12. Avery R, Pohlman B, Adal K. et al: High prevalence of diarrhea but infrequency of documented C. difficile in autologous peripheral blood progenitor cell transplant recipients. Poster presentation, ASTP, 1997, Abstract #533.
13. Avery R, Mossad S, Pelegri D et al: Prophylaxis of primary cytomegalovirus infection and disease after heart transplantation: does adding cytomegalovirus immune globulin to ganciclovir help? Oral presentation, ASTP 1997, Abstract #282.
14. Avery R, Brakeman J, Adal K, Henderson JM, Bolwell B, Longworth D et al: Infectious outcomes in transplantation in international patients. Poster presentation, IDSA 35th Annual Meeting, 1997.

## **BIBLIOGRAPHY**

1. Raba JM, Joseph H, Avery RK et al. (1990) Homelessness and AIDS. In Under the Safety Net: The Health and Social Welfare of the Homeless in the United States, eds. P.W. Brickner et al, W.W. Norton, New York/London.  
  
(The above book received the World Hunger Year's World Hunger Media Award for Best Book for 1990)
2. Avery RK (1991). AIDS and HIV Infection. In The Manual of Common Communicable Diseases in Shelters, eds. James J. O'Connell and Janet Groth, Boston Health Care for the Homeless Program.
3. Avery RK, O'Connell JJ (1992). Human Immunodeficiency Virus and Homeless Persons. In Deliverina Health Care to Homeless Persons, eds. David Wood. Springer Publishing Company.
4. Avery RK, Bleier KJ, Pasternack MS (1992). Differences between ATP-mediated cytotoxicity and cell-mediated cytotoxicity. J Immunol, August, 1992.
5. Avery RK, Baker AS. Chlamydial infection. In Principles and Practice of Ophthalmology, eds. Daniel M. Albert and Frederick A. Jakobiec, W.B. Saunders, 1994.
6. Avery RK, Madoff S, Zartman G, Baker AS: Mycoplasma hominis wound infection. Infect Dis Clin Pract, 1994;3(1):32-34.
7. Avery RK : Infections and immunizations in organ transplant recipients: a preventive approach. Cleveland Clinic J Med 1994;61(5):386-392.
8. Avery RK, Salman S, Baker AS: Rhinoscleroma treated with ciprofloxacin: a case report. The Laryngoscope, 105:1-3, July 1995.
9. Avery RK, Longworth DL: Viral pulmonary infections in thoracic and cardiovascular surgery. Semin Thorac Cardiovasc Surg 1995;7:88-94.
10. Wagner L, Avery RK, Bensinger L, Kusnitz F, Hibberd PL, Pasternack MS: Inhibition of cytotoxic T lymphocyte-triggered apoptosis by target cell surface-coupled aprotinin. Mol Immunol 1995, 32(12):853-864.
11. Avery RK, Pasternack MS: Approach to the adult patient with recurrent infections. Cleveland Clinic J Med 1997, 64(5):249-257.
12. Mayes JT, O'Connor BJ, Avery R et al: Transmission of Toxoplasma aondii infection by liver transplantation. Clin Infect Dis 21:511-5, 1995.

13. Dodds EM, Lowder CY, Foster RE, Avery RK, Prayson RA. Serous retinal detachments in a patient with clinically resistant cytomegalovirus retinitis. Archives of Ophthalmology. 1996 July;114(7):896-897.
14. Avery RK, McCarthy P, Mossad S et al: CMV Prophylaxis in heart transplant recipients. In preparation.
15. Charles R, Brzezinski A, Avery RK, et al: Case report. Disseminated cytomegalovirus infection presenting as Crohn's disease with pyoderma gangrenosum In preparation.
16. Levin L. Avery RK, Shore J. Woog, J, Baker AS. The spectrum of orbital aspergillosis. Survey of Ophthalmology, 1996, 41:142-54.
17. Avery RK, Eavey RD, Torre TD, Ramos D, Pasternack MS. Bilateral otitis media and mastoiditis caused by a highly resistant strain of *Mycobacterium chelonae*. Pediatric Infectious Disease Journal 1996 Nov;15(11):1037-1040.
18. Kathawalla SA, Stillwell PC, Gordon S, Haug M, Perl M, Arroliga AC, Metha AC, Avery R, Kirby T. Cytomegalovirus infection in seromismatched lung transplant recipients with and without prophylaxis with CMV immunoglobulin. Transplant Proc 1996 Dec;28(6 Suppl 2):16.
19. Avery RK, Brakeman J, Adal K, Bolwell B, Henderson JM, Novick A, Longworth DL. Infections in international transplant recipients. To be submitted to Transplantation
20. Avery RK, Barnes D, Teran J et al: *Listeria monocytogenes* tricuspid valve endocarditis with septic pulmonary emboli in a liver transplant recipient. Transplant Infectious Disease 1999 Dec;1(4):284-287.
21. Mossad S. Avery RK, Goormastic M, Hobbs RE, Stewart R, Significance of positive cultures from donor left atrium and post-preservation fluid in heart transplantation. Submitted to Transplantation.
22. Braun WE, Avery RK, Gifford RW Jr, Straffon RA. Life after 20 years with a kidney transplant: redefined disease profiles and an emerging nondiabetic vasculopathy. Transplant Proc 1997;29:247-249.
23. Muruve NA, Novick AC, Goldfarb DA, Flechner S, Dennis V, Avery R, Hodge EE. Risk factors, management, and outcome in renal transplant recipients experiencing CMV infections. (Submitted to Transplantation).
24. Avery RK. Transplant infectious disease: messages for the generalist. (submitted to CCJM)

25. Husni R, Northington D, Goldman M, Camisa C, Avery RK. Severe cutaneous reactions to vancomycin: report of three cases and review of the literature. (To be submitted).
26. Nasser RM, Hajjar I, Sandhaus L, Bolwell BM, Avery RK, Longworth DL, Hall GS, Adal KA. Routine cultures of Bone Marrow and Peripheral Stem All Harvests: Clinical Impact, cost analysis, and review of the literature. Submitted for publication.
27. Khan A, Lytle B, Taylor P, Longworth DL, Dorosti K, Walsh M, Avery RK. The spectrum of highly symptomatic cytomegalovirus infection after non-transplant cardiac surgery. (To be submitted).
28. Avery RK, Baker AS. Chlamydial Disease. Chapter 250 (revision for 1997 edition): Principles and Practice of Ophthalmology, Second Edition, WB Saunders.
29. Helm TN, Avery RK, Tomecki KJ. Respiratory dimorphic fungal infections. In Toxics in Clinical Dermatology, et. Boni E. Elewski, 1997.
30. LaRosa S, Gordon S, et al. Should prophylaxis for *Pneumocystis carinii* pneumonia in solid organ transplant recipients ever be discontinued? Submitted for publication.
31. Husni R, Gordon SM, Longworth DL, Arroliga A, Stillwell P, Avery RK, Maurer JR, Mehta A, Kirby T. Cytomegalovirus infection is a risk factor for invasive aspergillosis in lung transplant recipients. Submitted for publication.
32. Avery, RK, Prevention and treatment of cytomegalovirus infection and disease in heart transplant recipients. Current Opinion in Cardiology, 1988 Vol. 13:122-129.
33. Dumot JA, Barnes DS, Younossi Z, Gordon SM, Avery RK, Domen RE, Henderon M, Carey WD: Immunogenicity of hepatitis A vaccine in decompensated liver disease. American J of Gastroenterology, 1999 Vol 94:1 601-1 604.
34. Mossad, SB, Tomford, JW, Avery, RK, Hussein, MA, Vaughn, KW: Isolated Primary Hepatic Lymphoma in a Patient with Acquired Immunodeficiency Syndrome. International Journal of Infectious Diseases, 1999 Vol 4 Number 1 : 57-58.
35. Avery RK, Pohlman B, Adal K, Bolwell B, Goldman M, Kalaycio M, Hall G, Andresen S, Mossad S, Schmitt S, Mason P, Longworth D. High prevalence of diarrhea but infrequency of documented *Clostridium difficile* in autologous peripheral blood progenitor cell transplant recipients. Bone Marrow Transplantation, 2000 Vol. 25: 67-69.

#### **OTHER PROJECTS IN PROGRESS**

1. Retrospective review of infections in allograft BMT recipients. Cleveland Clinic Foundation 1992-95. 1. CMV prophylaxis. 2. Utility of BAL and open lung

- biopsy. 3. Infections in sulfa-intolerant patients.
2. Infectious complications in long term (15-20 year) recipients of renal transplants (with W. Braun, M.D.)
  3. Hypogammaglobulinemia in lung transplant recipients. With Dr. N. Goldfarb and Dr. J. Maurer.

### **GRAND ROUNDS PRESENTATIONS**

- 10-14-93 Medical Grand Rounds, Cleveland Clinic Foundation (with Dr. Steven Gordon) "New and Emerging Infectious Disease Pathogens in the 1990's."

### **OTHER TALKS**

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|---------------------|---|
| October 20-21, 1993 | "Infections and Immunization in the Renal Transplant Patient." Nephrology Update. Cleveland Clinic Foundation.                    |
| November 15, 1993   | "Infections and Immunization in the Renal Transplant Patient." American Society of Nephrology Boston, Massachusetts               |
| December 22, 1993   | infectious Disease Grand Rounds, Cleveland Clinic Foundation. "Infectious Diseases and the Skin".                                 |
| January 18, 1994    | "infectious in the Immunocompromised Host", Cleveland Clinic Foundation.  |
| February 9, 1994    | "What's New in Transplant ID". Infectious Disease Grand Rounds, Cleveland Clinic Foundation                                       |
| 1994-1995           | "Liver Disease After Transplantation". Infectious Disease Grand Rounds, Cleveland Clinic Foundation.                              |
|                     | "Role of Superantigens in Disease Causation." Infectious Disease Grand Rounds. Cleveland Clinic Foundation                        |
| September, 1995     | "Reconstitution of the Immune System after Bone Marrow Transplant". Infectious Disease Grand Rounds, Cleveland Clinic Foundation. |
| January 24, 1996    | "Unusual Causes of Lymphadenopathy". Infectious Disease Grand Rounds, Cleveland Clinic Foundation.                                |
| March 1996          | Workshop: Medical Management of Renal Transplant Patients,  |

With Drs. W. Braun, D. Goldfarb and B. Brouhard, Nephrology Update 1996.

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|------------------|--|
| May 1996         | American Society of Transplant Physicians. Luncheon Workshop, Post-Transplant Infections, with Dr. Robert Rubin.                           |
| June 1996        | "Infections in the Immunocompromised Host", Cleveland Clinic Eighth Annual Intensive Review of Internal Medicine.                          |
| August 1996      | Martin C. McHenry Symposium;"Transplant Infectious Disease for the Generalist."  |
| Nov. 1996        | Medical House Staff Conference "Infections in the Immunocompromised patient."  |
| March 5, 1997    | Infectious Disease Grand Rounds: Infections in Autologous Bone Marrow Transplant Recipients: Research Update. Cleveland Clinic Foundation. |
| March 12, 1997   | "Infectious complications in recipients of Autologous Peripheral Stem Cell Transplants, Medical College of Ohio.                           |
| March 19, 1997   | Nephrology Update 1997 Workshop: Medical Management of the Renal Transplant Patient  |
| May 22, 1997     | Tick-Borne Diseases. In "2nd Annual May Day Therapy: Dermatology", Cleveland Clinic Foundation.  |
| June 3, 1997     | Lung Transplantation: Infections and You. Second Wind Lung Transplant Support Group.   |
| October 27, 1997 | Talk to Skin Care Team; "skin Infections"  |
| November 4, 1997 | Medical House Staff. Noon conference. "Infections in the Immunocompromised Host."  |
| November 3, 1998 | I.D. Subspeciality Conference at Fairview Hospital: "Infections In Renal Transplant Patients   |
| November 2, 1999 | I.D. Conference at Fairview Hospital: "Granulocytopenia, Immuno Comp Host and Infections."   |

#### **INTRA-DEPARTMENTAL TEACHING**

Monthly Transplant ID Lunch conference (case presentations, discussions, with Dr. Sherif Mossad).

Extensive teaching of fellows, residents, and students on ID inpatient consult service (12 weeks/year), primary service (4 weeks/year), Bone Marrow service and Outpatient Modules (rest of year.)

#### **OUTSIDE MEDICAL ACTIVITIES**

Cleveland Health Care for the Homeless: Wednesday afternoon clinics at Payne Avenue Clinic and Monday evening clinics at City Mission (volunteer service). Providing direct care (general internal medicine) to homeless patients with a wide variety of conditions; supervising and teaching nurses in the Homeless Program and rotating CCF primary care residents.

#### **PROFESSIONAL SOCIETIES AND COMMITTEES**

American Society of Transplant Physicians, Member 1997 (ASTP)

Post Transplant Infections Committee

Visiting Faculty Program, "Progress in Prevention of CMV Disease in **Solid** Organ Transplantation," Sponsored by Tufts University (1997)

Viral Hepatitis Clinical Guidelines Committee, Cleveland Clinic Foundation (1997)