# 484

1 State of Ohio, ) 2 County of Cuyahoga.) 3 IN THE COURT OF COMMON PLEAS 4 5 THOMAS M. GILBERT, etc., 6 Plaintiff, 7 Case No. 315,071 vs. 8 Judge William Coyne EMAD DEAN NURTA, M.D., 9 et al., 10 Defendants. 11 12 DEPOSITION OF MARK JUDSON BOTHAM, M.D. Wednesday, January 7, 1998 13 14 15 The deposition of MARK JUDSON BOTHAM, M.D., 16 a witness, called for examination by the Plaintiff 17 under the Ohio Rules of Civil Procedure, taken 18 before me, Diane M. Stevenson, a Registered Merit 19 Reporter and Notary Public in and for the state 20 of Ohio, by agreement of counsel, at Mt. Sinai 21 Medical Center, 1 Mt. Sinai Drive, Cleveland, 22 Ohio, commencing at 5:10 p.m., the day and date 23 above set forth. 24 25 Diane M. Stevenson, RMR Morse, Gantverq & Hodqe

## Gilbert v. Nukta

## Multi-Page<sup>™</sup>

## Botham, M.D.

Gilbe	rt v. Nukta Mul	lti-Page	Botham, M.D.
1	APPEARANCES: Page	2	Page 4
2	on behalf of the Plaintiff:	1	Exhibits 1 and 2. No. 1 is your CV. Does that
3	George E. Loucas, Esq.	2	appear accurate and up-to-date?
4	George E. Loucas Co., LPA 600 Standard Building	3	First of all, is that what it is?
5	Cleveland, Ohio 44113	4 A.	Yes, it is.
6	On behalf of the Defendant, Dr. Nukta:	5 Q.	Is it up-to-date, or would you like to make any
7	William A. Meadows, Esq.	6	additions?
3	Richard A. Vadnal, Esq. Reminger & Reminger Co., LPA		No, this is up-to-date.
9	The 113 St. Clair Building Cleveland, Ohio 44114	8 Q.	Is there anything in publication or pending that
10		9	is not on there?
11	On behalf of the Defendant, Fairview General Hospital:	10 <b>A</b> .	
1.2	Kris Treu, Esq.	11 Q.	No. 2 is the report that you have prepared in the
1.3	Moscarino & Treu Co., LPA 812 Huron Road, Suite 490	12	case?
14	Cleveland, Ohio 44115	13 <b>A</b> .	1
15		-	Would you like to make any changes or supplement
16		15	that in any way today?
17		16 A.	
18			You stand by what is written there, correct?
19		18 A.	
20			Relative to the CV, I would like you to please go
21		20	to the articles and tell me whether any have
22		21	application directly or indirectly relative to
23		22	the subjects today, namely to the opinions you
24		23	will be providing?
25			No, they do not.
ļ		25 Q.	Number 4, "Dissociation Between Epicardial and
	Page	3	Page 5
1	MARK JUDSON BOTHAM ,M.D.	1	Transmural Function," et cetera, any application
2	A witness, called for examination by the	2	there to the end event or the infarct that we are
3	Plaintiff, under the Rules, having been first	3	going to talk about today?
4	duly sworn, as hereinafter certified, was	4 A	
5	examined and testified as follows:	5 Q.	Under "Societies," you list "International
6	CROSS-EXAMINATION	6	Association for Cardiac Biological Implants,
7	BY MR. LOUCAS:	7	1991." First of all, was that the only year you
8 Q.	Good evening, Doctor. We have just been	8	were involved in that society?
9	introduced. My name is George Loucas, and I	1	No. I am a member of that society today.
10	represent the estate of Janice Gilbert, as you		What is the nature of that society?
11	know.	1	It is a society of cardiac surgeons that are
12	I am going to be asking you some questions	12	involved in discussions, talking about the
13	relative to the expert opinions you have been	13	risks/benefits of utilizing biological implants
14	retained to provide in this case. Mainly, my	14	for valve surgery rather than mechanical valve
15	goal here today is just to find out what opinions	15	implants.
16	you have, the bases for those opinions, what		Does it involve only surgeons, or also cardiolo-
17	opinions you will be providing at trial.	17	gists?
18	Fair enough?		Primarily surgeons.
19 A.		i	So it also involves cardiologists?
	I take it you have had your deposition taken		I am sure there are some cardiologists who are
21	before, correct?	21	members of the society, just as there are cardiac
22 A.		22	surgeons who are members of cardiologic societies.
23	(Thereupon, Plaintiff's Exhibits 1 and 2	23	I wouldn't know the actual mix.
224	were marked for identification.)	24 Q.	E I
25 Q.	I have handed you two exhibits, Plaintiff's	:25	relating to the valves, such as stents?

Gilbert v. Nukta	Multi-Page <sup>™</sup>	Botham. M.D.
	Page 6	Page 8
<ol> <li>A. No. It involves specifically related to</li> <li>implantations of valves.</li> </ol>	1 a package in the mail without 2 talked to somebody about wh	t at least having
3 Q. Do you know any of the experts that are going		•
4 be testifying in this case?	4 getting to.	
5 A. No, I do not.	5 A. No, I have that happen relativ	ely frequently.
6 Q. Do you know of Morton Kern?	6 Q. Have you worked with Bill M	
7 A. I don't know him personally, no.	7 case other than this?	
8 Q. You know of him, however?	8 A. No, I have not.	
9 A. The name sounds familiar, but I don't know h	im, 9 Q. Do you know Bill personally	?
0 personally.	0 <b>A.</b> No.	
1 Q. How about Dr. Nukta, do you know Dr. Nukta		f his firm, Reminger &
2 A. I do not.	2 Reminger, personally?	
3 Q. You have never met him directly or indirectly	-	s, or outside of the
4 <b>A.</b> No.	4 physician-attorney	
5 Q. Have you ever had had any conversations with		
6 A. No, I have not.	6 A. No, I do not.	
7 Q. Relative to this case I mean.	7 Q. How about his former firm, C 8 A. No.	Janagner, Snarp?
8 A. No, I have not,		worked with any
9 Q. Have you conversed or talked with any of the	<ul><li>9 Q. Professionally, then, have you</li><li>0 other members of Reminger &amp;</li></ul>	
<ul><li>0 other experts in this case?</li><li>1 A. No.</li></ul>	0 other members of Reminger &	e Kenninger, consulteu?
2 Q. Do you know Dr. Bowman?	2 Q. Who would that be?	
3 A. No, I do not.	3 A. Stephen Crandall and Jim Ma	alone
4 Q. How about Dr. Tice, have you heard of Dr. Ti	-	
15 A. No.	5 present?	terninger, pust of
	Page 7	Page S
1 Q. Likewise Dr. Feit. Have you ever heard of	<b>1</b> A. I do have a case that I am wo	rking with Stephen
2 Dr. Feit?	2 Walters.	
3 A. No, I don't know him.	3 Q. What case is that?	
4 Q. How is it you became involved in this case?	4 MR. MEADOWS: I an	n going to object
5 A. I was sent a packet of information by Mr. Me	-	
6 and asked if I would be willing to review this	6 you have not issued a report	
7 case for his defendant.	7 believe that reports or your id	
8 Q. You were just cold called, received a packet in	-	
9 the mail, or was there a telephone call first	9 parties, it would be considered	ed a work product
0 A. I suspect probably a package arrived, and then		. 1 1 1 1
1 received a phone call from Mr. Meadows.	1 A. It is a work product. No rep	
<ul> <li>2 Q. You have to wait until I finish my question ju</li> <li>3 so that Diane can get it all down before you</li> </ul>		chance to discuss
	5	to the best of your
4 start. I was going to ask you: Or did somebo 15 make contact with you to see if you would act		
16 a package upon its arrival?	6 Reminger?	
17 A. I don't know whether there was a phone call	7 A. Probably half a dozen.	
18 before or whether the material arrived before t		n any of those
19 phone call.	19 cases, either deposition or tri	-
20 Q. Do you have some relationship with Bill Mea	-	
<sup>21</sup> where he could just send you things in the ma		ve been presented,
<sup>22</sup> and then accept a phone call as to whether you		-
23 would be willing to take them?	23 consulted, how many have th	
<sup>24</sup> A. No, I do not.	24 opinion was that it was a me	-
25 Q. I mean, I just find it odd that you would recei	ve 25 A. On probably two occasions, 2	yes. On one occasion

Gilbe	rt v. Nukta Mult	i-Pa	age	<sup>TM</sup> Botham, M.D.
	Page 10			Page 12
1	I think the discussion revolved around the fact	1		courtroom on a yearly basis?
2	that I could not provide them defensible	2	A.	Once or twice.
3	testimony.	3	Q.	I am relating that to medical malpractice.
4 Q.	Have you had that type of professional	4	A.	Total, yes.
5	relationship at all with Gallagher, Sharp?	5	Q.	Have you worked with any of the plaintiff's firms
6 A.	I have not.	6		here in town?
7 Q.	Have you consulted with any other defense firms	7	A.	Yes, I have.
8	here in Cleveland?	8	Q.	What firms would that be?
9 A.	Yes.	9	A.	Nurenberg, Plevin. I have worked with Steve
0 Q.	About how many, or what other firms?	10		Charms on a couple of occasions.
1 A.	Jacobson, Maynard is probably the one that I have	11	Q.	Is that when Steve was with Jacobson, Maynard, or
2	done the overwhelming majority for.	12		since then?
3 Q.	Were you a PIE insured?	13	A.	No, as a plaintiff's counsel.
4	MR. MEADOWS: Show an objection.	4	Q.	On the occasions that you are consulted by
5 A.	At one time I was, yes.	15		plaintiffs on behalf of the patient, are you able
6	(Thereupon, a discussion was had off the	16		to give me a percentage of times, approximately,
7	record.)	17		where you find that it is a meritorjous case
8 Q.	About how many years have you been doing	18		versus not being the case?
9	consulting work?	19	A.	I would say 50 percent of the time.
0 <b>A</b> .	Ten years.	20	Q.	Have you ever had occasion to consult in a case
1 Q.	On medical malpractice issues?	21		with issues relating to an aortic dissection?
2 <b>A</b> .	Yes.	22	A.	Numerous.
3 Q.	About how many do you take on a yearly basis?	23	Q.	When you say "numerous," about how many?
4 A.	It varies. Anywhere between 10 and 12, maybe 15	24	A.	Two this year alone. It is a very frequent
5	on a busy year.	25		source of litigation.
	Page 11			Page 1.
1 Q.	May I ask what your rate is?	1	Q.	Is it a frequently occurring complication?
2 A.	For hourly consultation?	2	A.	It is a frequently occurring problem. I wouldn't
_	Yes.	3		say frequently occurring complication.
	\$250 an hour.		-	What is the basis your distinction?
-	How about for deposition testimony?	5	A.	Well, if you are ascertaining whether or not it
6 A.	That depends upon whether it is a half day loss	6		is a frequent occurrence in the general populous,
7	of work or full day. Half day is usually \$4,000	7		the answer would be yes. As a complication of a
8	or \$5,000. Full day is \$10,000.	8		medical procedure that is a complication, the
	Trial testimony?	9		answer would be no.
	Samething.	10	Q.	So you are drawing a distinction between
1 Q.	What will you be charging, then, for this	ΙI		spontaneous dissection versus iatrogenic?
2	deposition testimony?	12	А.	Yes.
	\$250 an hour.	13	Q.	Are you able to give me a rate of this
4 Q.	Thank you. Of the range that you gave me, 10,	14		complication iatrogenically?
5	sometimes 15 per year, are you able to give me a	15	A.	It depends upon whether it occurs during an
6	breakdown or percentage of how many would be on	16		invasive cardiologic procedure or whether it
7	behalf of the patient versus the medical care	17		occurred during a cardiac surgical procedure.
18	provider?	18	Q.	What is the difference, in other words, the
	I believe you asked me how many defense cases I	19		percentage of each?
20	do, and I told you about maybe 10 or 12. I	20	A.	The rate in an invasive cardiologic procedure
21	probably do another five or seven for plaintiff's	21		probably would be less than 1 in 10,000, I would
22	counsel.	22		suspect. In a cardiac surgical procedure it
	On a yearly basis?	23		probably would be 1 in 1,000 or 1 in 700,
	Yes.	24		somewhere in that range.
15 0	How often do you find yourself testifying in a	25	0	You said "suspect." Why did you say "suspect"?

Gilbe	rt v. Nukta Mul	ti-Page	<sup>TM</sup> Botham, M.D.
	Page 14	4	Page 16
1 A,	It depends upon the surgeons involved. Some	1 A.	An interventional cardiac catheterization?
2	surgeons have a higher incidence of iatrogenic	2 Q.	Yes.
3	aortic dissection than others.	3 A.	No.
4	The reported rate is somewhere between 1 in	4 Q.	Have you ever done an angiography?
5	700 and 1 in 1,000.	5 A.	
6 Q.	Is that something that you would expect cardiolo-	6 Q.	Do you consider those one and the same?
7	gists or surgeons who are doing interventional	7 A.	Well, they are both ascertaining the same thing,
8	work to keep track of their complications?	8	looking at the character of a blood vessel in the
9 A.	No, because it happens so infrequently, a guy	9	body.
10	would have to do 10,000 or 20,000 or 30,000	10	A cardiac catheterization relates specifi-
11	cardiac catheterizations to have one or two	11	cally to those blood vessels that are pertinent
12	develop. And he may do 30,000 and never have	12	to the heart. Angiography could be something
13	this complication.	13	related to an artery that travels anywhere else
14 Q.	I am sorry, I didn't mean to interrupt. I didn't	14	in the body.
15	mean specifically the complication of aortic	15 Q.	what is the basis for your opinion that
16	dissection, I am talking about complications in	16	iatrogenic complications occur more frequently in
17	general, to see if there is a pattern or perhaps	17	cardiac surgery?
18	something is occurring more frequently than	18 A.	Because, as a cardiac surgeon, we" are poking
19	others.	19	holes in the aorta on a much more frequent basis
20 A.	In general, that is not something that a	20	than would be a cardiologist with a cardiac
21	cardiologist himself would keep track of.	21	catheter. I mean, we routinely make three or
22	Usually that is kept track of by the cardiac	22	four or five holes in the aorta transmurally
23	catheterization laboratory where the cardiologist	23	through the wall of the aorta in every operation
24	is doing his work.	24	that we do.
25 Q.	Do you have a complication list that you keep for	25 Q.	Is that like to attach grafts and things like
	Page 1	5	Page 17
1	yourself?	1	that?
	No, I do not.		Place on the patient cardiopulmonary grafts and
	I take it, then, the hospital would do that for	3	hook up bypass grafts, replace the aorta.
	you, as well, more likely than not?		Can a dissection of the aorta occur then when you
	They may or may not. We obviously have a peer	5	are poking holes to put a graft in? Is that how
6	review system where we review all of our	6	that typically happens?
7	complications, so it is kept track.		They can occur at that time. They can occur from
	So somebody keeps track, though? Yes.	8	a cannulation site. They can occur from a
	Do you ever find yourself reviewing that	9 10	placement of a cross clamp to separate one portion of the aorta from the blood flow. They
10 Q.	complication list, just to make yourself a better	11	occur from placement of the sutures in the
12	surgeon?	12	proximal portion of the bypass graft.
	Whenever I do have a complication that I feel was		What is the most frequent of those mechanisms you
14	something that could have developed in the	13 Q.	have just mentioned?
15	operating room, I always review that to see if		Probably evenly divided between cannulation sites
16	there are other avenues by which I may have	16	and cross clamp placement.
17	pursued a different course that resulted in a	17	(Thereupon, a discussion was had off the
18	different outcome.	18	record.)
	Fair enough. But you have the ability to access	19 Q.	
20	that list and take a look if you want to. Fair	20	for a dissection during cardiac surgery is I
21	enough?	21	wanted to know what you believe to be the
22 A.	0	22	similarities and the nature of the dissections
23 Q.	I am still curious about your use of the word	23	between cardiac surgery versus interventional
24	"suspect" for less than 1 in 10,000. Have you	24	cardiology.
25	ever done an interventional procedure?	25 A.	The mechanisms are one and the same. It is a
			Раде 14 - Раде 17

Gilbe	rt v. Nukta Mu	lti-P	ag	$e^{TM}$ Botham, M.D.
	Page	18		Page 20
1	disruption of the intima that allows blood to	1	A	. I am familiar with it. I don't use it on a
2	enter the media, which is usually diseased, and	2		regular basis. I am aware of the terminology. I
3	allows the propagation of that false lumen to	3		wouldn't be able to specifically tell you which
4	develop in either antegrade or retrograde	4		catheter is which.
5	fashion.	5	i Q	Likewise, you would be unable to tell me the
6 Q.	Do you believe Janice Gilbert's aortic media was	6		complication rates for the catheter he was using
7	diseased?	7	,	in terms of dissections of the RCA or the aorta?
8 A.	Yes.	8	A A	. In terms of whether one catheter has a higher
9 Q.	In what way, please?	9		complication rate than the other?
	Well, for one reason or another, the media itself	10	Q	. Correct.
11	did not stay in the same measurable plane as the		_	. I wouldn't be able to tell you the exact numbers.
12	intima and adventitia. She developed a	1		. Would you defer to an interventional cardiologist
13	dissection from a small puncture site in the	13		in that regard?
.14	intima.			. I don't know whether I would say "defer." They
	I am sorry, can you repeat that?	15		would have a better handle with the actual
16 <b>A</b> .		16		numbers.
10	blood to get into the media in her case was not			Do you know the name or the type of catheter that
.18	contained, it resulted in a dissection.	18		he was using at the time of the aortic dissection
.18	I puncture the intima thousands of times	19		of Janice Gilbert?
20	every year and don't get dissection. So there	20		1 just wondered if you knew it off the top
20 21	has to be something wrong in this woman's media	20		of your head. In a moment I will tell you to go
21	• •	22		ahead and look at the records.
	that allows a simple puncture site to result in a dissection.	1		
23		1		. No, I would have to look to refresh my memory.
	What makes you believe that it was a puncture	24		When you were reviewing this case, did you
.25	site? What do you mean by "puncture"?	25	)	entertain any notion that that type of catheter
	Page	19		Page 21
1 A.	Well, you have to make a laceration in the intima	1		was at increased risk for the complication?
2	somewhere to initiate the dissection.			. No, I did not.
3 Q.	You said blood, "which allowed blood in the	3	3 Q	Doctor, I am <i>sorry</i> , was known to have an
4	media." What makes you believe it was blood in	4	ł	increased risk of complication of the aortic
5	the media?	5	5	dissection?
6 A.	That was what was being pumped into the heart out	it e	5 A	. No, I did not.
7	of the aorta.	7	Q	Assuming that to be true, would you agree with me
8 Q.	How about contrast medium?	8	3	that the interventional cardiologist would have a
9 A.	Well, there is free communication between the	9	)	corresponding duty or responsibility to observe
10	true and false lumen, although there was contrast	0	)	for that complication if there was an increased
11	material within the wall of the aorta, it flows	1	L	likelihood for it with that catheter?
12	in and out freely, and it is admixed with blood.	2	2	MR. MEADOWS: Objection.
13 Q.		3	3 A	. I <i>think</i> any time you do an invasive procedure it
14	aorta there would be contrast material mixed with	4		behooves you to be aware of the complications
15	blood, correct?	4		that can develop, and always be suspect for that
16 <b>A</b> .		6		complication should it arise, regardless of what
17 Q.				type catheter you use.
18	you referring?			If the complication did develop with
	The false lumen is that lumen that develops as a	9		catheter A or catheter B, it behooves you to have
20	result of the dissection. It is blood traversing	20		the same level of attentiveness, regardless of
20	between the media and the adventitia of the	21		the type of catheter.
22	aorta.	22		
22 23 Q.		23		raise a duty or a responsibility on the part of
-	was used by Dr. Nukta in this case, meaning the			the interventional cardiologist to keep that
24 25	Judkin's catheter and the French, et cetera?	22		within the field of vision where the dissection
25	Judkin 5 cameter and me French, et cetera?	24	נ	Page 18 - Page 2

TIDE	rt v. Nukta Multi	-Page	Botham, M.
	Page 22		Page
1	may occur?	1	andexpired.
2	MR. MEADOWS: Objection.	2 Q.	Why did you believe it was a defensible case?
3 Q.	In other words, the junction of the right	-	Because I was defending the emergency room
4	coronary artery with the aorta.	4	physician who saw him, and I did not feel at that
5	MR. MEADOWS: Objection.	5	point in time that there was evidence within the
	I think it is always nice to have a completely	6	medical record of his emergency room visit to
7	wide field to be able to visualize everything	7	point to an aortic dissection as the etiology of
8	during a cardiac catheterization. But that just	8	his complaint.
	doesn't happen. It is not a reality.		Were there any laboratories in that situation,
0	The camera is routinely up and down around	10	such as an echocardiogram or x-rays?
1	the patient around the area where you are trying	11 A	- · ·
2	to visualize. It is not always focused specifi-		Or anything?
3	cally on one spot. That is why they have the		Chest x-rays and laboratory studies were all
, 1	ability in a cardiac catheterization lab to pan	15 A.	normal.
5	the camera, to move it around. It is never		
			How about the second one, if you could go ahead and talk about that.
)	specifically directed in just one view at	16	
	everything that you want to see.		That is one that I am presently working on that,
	You said you were working on two cases this year	18	again, as Mr. Meadows has alluded to, there is
)	of aortic dissections?	19	work product.
	One is presently being looked at, and one has	1	In Cleveland, though?
	been actually settled.		That is a case being done in Cleveland.
	Would you tell me what side you were on in each		Have you been asked to consult on behalf of the
;	of the cases?	23	defense on that one?
	Actually, there are three. I apologize. One was		No. That is a plaintiff's case for Nurenberg,
5	settled for the plaintiff. I was a defense	25	Plevin,
	Page 23		Page
1	expert.		The third one?
2	MR. MEADOWS: Show a continuing	2 A.	That is a case that I just received, again from
3	objection. Again, I am going to caution you,	3	Bruce Vandevusse, which no suit has actually bee
4	Doctor, if there is an instance amongst one of	4	brought, but he asked my opinion regarding it
5	these three where you have been consulted but not	5	because he feels there is a relatively high
6	necessarily revealed as an expert to the opposing	6	likelihood that a case will be brought.
7	party, you should not mention that case by name		Ũ
		7 Q.	Have you rendered an opinion yet in that case?
8	or description, because that is work product.	-	0
	or description, because that is work product. The one that has been settled was settled for the	8 A	Have you rendered an opinion yet in that case? I have not.
9 A.		8 A	Have you rendered an opinion yet in that case? I have not.
ЭА. )	The one that has been settled was settled for the	8 A 9 Q.	Have you rendered an opinion yet in that case? I have not. How many others? You talked about <b>three</b> that an
) A. ) 1 Q.	The one that has been settled was settled for the plaintiff. I was a defense expert.	8 A 9 Q. 10 11	<ul><li>Have you rendered an opinion yet in that case?</li><li>I have not.</li><li>How many others? You talked about three that an currently pending. How many others have you</li></ul>
<ul> <li>A.</li> <li>Q.</li> <li>A.</li> <li>A.</li> <li>A.</li> <li>A.</li> </ul>	The one that has been settled was settled for the plaintiff. I was a defense expert. Who were counsel, if you recall, please?	8 A 9 Q. 10 11	<ul><li>Have you rendered an opinion yet in that case?</li><li>I have not.</li><li>How many others? You talked about three that an currently pending. How many others have you consulted?</li></ul>
9 A. 0 1 Q. 2 A. 3	The one that has been settled was settled for the plaintiff. I was a defense expert. Who were counsel, if you recall, please? Bruce Vandevusse in Detroit, Michigan was defense	8 A 9 Q. 10 11 12 A. 13	<ul> <li>Have you rendered an opinion yet in that case?</li> <li>I have not.</li> <li>How many others? You talked about three that an currently pending. How many others have you consulted?</li> <li>One that has been settled and two that are</li> </ul>
9 A. 0 1 Q. 2 A. 3 4	The one that has been settled was settled for the plaintiff. I was a defense expert. Who were counsel, if you recall, please? Bruce Vandevusse in Detroit, Michigan was defense counsel, and I don't recall the plaintiff's	8 A 9 Q. 10 11 12 A. 13	<ul> <li>Have you rendered an opinion yet in that case?</li> <li>I have not.</li> <li>How many others? You talked about three that an currently pending. How many others have you consulted?</li> <li>One that has been settled and two that are pending.</li> </ul>
9 A. 0 1 Q. 2 A. 3 4 5 Q.	The one that has been settled was settled for the plaintiff. I was a defense expert. Who were counsel, if you recall, please? Bruce Vandevusse in Detroit, Michigan was defense counsel, and I don't recall the plaintiff's counsel.	8 A 9 Q. 10 11 12 A. 13 14 Q.	<ul> <li>Have you rendered an opinion yet in that case?</li> <li>I have not.</li> <li>How many others? You talked about three that an currently pending. How many others have you consulted?</li> <li>One that has been settled and two that are pending.</li> <li>I am sorry. Thank you. Other than these three,</li> </ul>
<ul> <li>A.</li> <li>A.</li> <li>Q.</li> <li>A.</li> &lt;</ul>	The one that has been settled was settled for the plaintiff. I was a defense expert. Who were counsel, if you recall, please? Bruce Vandevusse in Detroit, Michigan was defense counsel, and I don't recall the plaintiff's counsel. Was this a Michigan case, then?	8 A 9 Q. 10 11 12 A. 13 14 Q. 15 16	<ul> <li>Have you rendered an opinion yet in that case?</li> <li>I have not.</li> <li>How many others? You talked about three that ar currently pending. How many others have you consulted?</li> <li>One that has been settled and two that are pending.</li> <li>I am sorry. Thank you. Other than these three, have you consulted medical-legally on any other aortic dissection cases?</li> </ul>
<ul> <li>A.</li> <li>Q.</li> <li>A.</li> &lt;</ul>	The one that has been settled was settled for the plaintiff. I was a defense expert. Who were counsel, if you recall, please? Bruce Vandevusse in Detroit, Michigan was defense counsel, and I don't recall the plaintiff's counsel. Was this a Michigan case, then? Yes.	8 A 9 Q. 10 11 12 A. 13 14 Q. 15 16 17 A.	<ul> <li>Have you rendered an opinion yet in that case?</li> <li>I have not.</li> <li>How many others? You talked about three that an currently pending. How many others have you consulted?</li> <li>One that has been settled and two that are pending.</li> <li>I am sorry. Thank you. Other than these three, have you consulted medical-legally on any other</li> </ul>
<ul> <li>A.</li> <li>A.</li> <li>Q.</li> <li>A.</li> &lt;</ul>	The one that has been settled was settled for the plaintiff. I was a defense expert. Who were counsel, if you recall, please? Bruce Vandevusse in Detroit, Michigan was defense counsel, and I don't recall the plaintiff's counsel. Was this a Michigan case, then? Yes. How do you spell his last name? V A N D E V U S S E .	8 A 9 Q. 10 11 12 A. 13 14 Q. 15 16 17 A. 18 Q.	<ul> <li>Have you rendered an opinion yet in that case?</li> <li>I have not.</li> <li>How many others? You talked about three that an currently pending. How many others have you consulted?</li> <li>One that has been settled and two that are pending.</li> <li>I am sorry. Thank you. Other than these three, have you consulted medical-legally on any other aortic dissection cases?</li> <li>In years past?</li> </ul>
<ul> <li>A.</li> <li>A.</li> <li>Q.</li> <li>A.</li> <li>A.</li> <li>A.</li> <li>Q.</li> <li>A.</li> <li>Q.</li> <li>A.</li> <li>Q.</li> <li>A.</li> <li>Q.</li> <li>A.</li> <li>Q.</li> <li>A.</li> <li>Q.</li> <li>Q.</li> </ul>	The one that has been settled was settled for the plaintiff. I was a defense expert. Who were counsel, if you recall, please? Bruce Vandevusse in Detroit, Michigan was defense counsel, and I don't recall the plaintiff's counsel. Was this a Michigan case, then? Yes. How do you spell his last name? V A N D E V U S S E . Was that an aortic dissection?	8 A 9 Q: 10 11 12 A. 13 14 Q. 15 16 17 A. 18 Q. 19 A	<ul> <li>Have you rendered an opinion yet in that case?</li> <li>I have not.</li> <li>How many others? You talked about three that an currently pending. How many others have you consulted?</li> <li>One that has been settled and two that are pending.</li> <li>I am sorry. Thank you. Other than these three, have you consulted medical-legally on any other aortic dissection cases?</li> <li>In years past?</li> <li>Yes.</li> </ul>
<ul> <li>A.</li> <li>A.</li> <li>Q.</li> <li>A.</li> <li>A.</li> <li>Q.</li> <li>A.</li> <li>Q.</li> <li>A.</li> <li>Q.</li> <li>A.</li> <li>Q.</li> <li>A.</li> <li>Q.</li> <li>A.</li> <li>Q.</li> <li>A.</li> &lt;</ul>	The one that has been settled was settled for the plaintiff. I was a defense expert. Who were counsel, if you recall, please? Bruce Vandevusse in Detroit, Michigan was defense counsel, and I don't recall the plaintiff's counsel. Was this a Michigan case, then? Yes. How do you spell his last name? V A N D E V U S S E . Was that an aortic dissection? Yes.	8 A 9 Q. 10 11 12 A. 13 14 Q. 15 16 17 A. 18 Q. 19 A 20 Q.	<ul> <li>Have you rendered an opinion yet in that case?</li> <li>I have not.</li> <li>How many others? You talked about three that an currently pending. How many others have you consulted?</li> <li>One that has been settled and two that are pending.</li> <li>I am sorry. Thank you. Other than these three, have you consulted medical-legally on any other aortic dissection cases?</li> <li>In years past?</li> <li>Yes.</li> <li>Yes.</li> <li>About how many, if you can recall?</li> </ul>
<ul> <li>A.</li> <li>A.</li> <li>Q.</li> <li>A.</li> <li>A.</li> <li>Q.</li> <li>A.</li> <li>Q.</li> <li>A.</li> <li>Q.</li> <li>A.</li> <li>Q.</li> <li>A.</li> <li>Q.</li> </ul>	The one that has been settled was settled for the plaintiff. I was a defense expert. Who were counsel, if you recall, please? Bruce Vandevusse in Detroit, Michigan was defense counsel, and I don't recall the plaintiff's counsel. Was this a Michigan case, then? Yes. How do you spell his last name? V A N D E V U S S E . Was that an aortic dissection? Yes. What was the mechanism of action in that case, or	8 A 9 Q. 10 11 12 A. 13 14 Q. 15 16 17 A. 18 Q. 19 A 20 Q. 21 A.	<ul> <li>Have you rendered an opinion yet in that case?</li> <li>I have not.</li> <li>How many others? You talked about three that an currently pending. How many others have you consulted?</li> <li>One that has been settled and two that are pending.</li> <li>I am sorry. Thank you. Other than these three, have you consulted medical-legally on any other aortic dissection cases?</li> <li>In years past?</li> <li>Yes.</li> <li>Yes.</li> <li>About how many, if you can recall?</li> <li>I would say probably another five or six.</li> </ul>
9 A. 0 1 Q. 2 A. 3 4 5 Q. 6 A. 7 Q. 8 A. 9 Q. 0 A. 1 Q. 2	The one that has been settled was settled for the plaintiff. I was a defense expert. Who were counsel, if you recall, please? Bruce Vandevusse in Detroit, Michigan was defense counsel, and I don't recall the plaintiff's counsel. Was this a Michigan case, then? Yes. How do you spell his last name? V A N D E V U S S E . Was that an aortic dissection? Yes. What was the mechanism of action in that case, or what were the facts in that case?	8       A         9       Q:         10       11         12       A.         13       14         14       Q.         15       16         17       A.         18       Q.         19       A         20       Q.         21       A.         22       Q.	<ul> <li>Have you rendered an opinion yet in that case?</li> <li>I have not.</li> <li>How many others? You talked about three that ar currently pending. How many others have you consulted?</li> <li>One that has been settled and two that are pending.</li> <li>I am sorry. Thank you. Other than these three, have you consulted medical-legally on any other aortic dissection cases?</li> <li>In years past?</li> <li>Yes.</li> <li>Yes.</li> <li>About how many, if you can recall?</li> <li>I would say probably another five or six.</li> <li>Of those five or six, do you recall whether any</li> </ul>
9 A. 0 1 Q. 2 A. 3 4 5 Q. 6 A. 7 Q. 8 A. 9 Q. 0 A. 1 Q. 2 3 A.	The one that has been settled was settled for the plaintiff. I was a defense expert. Who were counsel, if you recall, please? Bruce Vandevusse in Detroit, Michigan was defense counsel, and I don't recall the plaintiff's counsel. Was this a Michigan case, then? Yes. How do you spell his last name? V A N D E V U S S E . Was that an aortic dissection? Yes. What was the mechanism of action in that case, or what were the facts in that case? It was a young man who came into the emergency	8 A 9 Q. 10 11 12 A. 13 14 Q. 15 16 17 A. 18 Q. 19 A 20 Q. 21 A. 22 Q. 23	<ul> <li>Have you rendered an opinion yet in that case?</li> <li>I have not.</li> <li>How many others? You talked about three that an currently pending. How many others have you consulted?</li> <li>One that has been settled and two that are pending.</li> <li>I am sorry. Thank you. Other than these three, have you consulted medical-legally on any other aortic dissection cases?</li> <li>In years past?</li> <li>Yes.</li> <li>Yes.</li> <li>Yes.</li> <li>About how many, if you can recall?</li> <li>I would say probably another five or six.</li> <li>Of those five or six, do you recall whether any of those were in Cleveland?</li> </ul>
0 11 Q. 2 A. 3 4 4 5 Q. 4 6 A. 17 Q. 18 A. 19 Q. 20 A. 21 Q. 22	The one that has been settled was settled for the plaintiff. I was a defense expert. Who were counsel, if you recall, please? Bruce Vandevusse in Detroit, Michigan was defense counsel, and I don't recall the plaintiff's counsel. Was this a Michigan case, then? Yes. How do you spell his last name? V A N D E V U S S E . Was that an aortic dissection? Yes. What was the mechanism of action in that case, or what were the facts in that case?	8       A         9       Q:         10       11         12       A.         13       14       Q.         15       16         17       A.         18       Q.         20       Q.         21       A.         22       Q.         23       24	<ul> <li>Have you rendered an opinion yet in that case?</li> <li>I have not.</li> <li>How many others? You talked about three that ar currently pending. How many others have you consulted?</li> <li>One that has been settled and two that are pending.</li> <li>I am sorry. Thank you. Other than these three, have you consulted medical-legally on any other aortic dissection cases?</li> <li>In years past?</li> <li>Yes.</li> <li>Yes.</li> <li>About how many, if you can recall?</li> <li>I would say probably another five or six.</li> <li>Of those five or six, do you recall whether any</li> </ul>

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Gilbe	rt v. Nukta Mult	i-Page	Botham, M.D.
	Page 26		Page 28
1	list with regard to the work that you have done	1	dissection if she did not have a pathologically
2	on cases?	2	abnormal aorta,
3 A.	No,	3 Q.	Would calcification be included within pathologi-
4 Q.	How about with regard to the income generated for	4	cally abnormal?
5	those cases?	5 A.	Calcification is included within pathologically
6 A.	I am sure I have W-2s dating back from but I	6	abnormal. But it, in and of itself, did not
7	don't keep a list of the income from it.	7	predispose someone to the development of a
8 Q.	You don't separate in any way? There is nothing	8	dissection.
9	we could look at to see	9 Q.	Are you aware of what the standard of care is as
	No, I don't separate it.	10	to whether interventional procedures should be
1 Q.	Of those five or six, approximately how many	11	undertaken, if at all, with a diseased aorta, as
2	would be for the defendant, medical care	12	you have so described?
3	provider, versus the patient?	13 A.	Invasive cardiologic procedures are undertaken
4 A.	All of the ones up until this year, anteceding	14	every day on patients who have diseased aortas.
5	this year's cases, have been for the defense.	15 Q.	So you are not familiar with any specific
6 Q.	I missed a word.	16	standard of care, then, that says in certain
7 A.	All of the cases anteceding this year's cases	17	instances it should not be undertaken with X
8	have been for the defense.	18	disease?
9 Q.	Thank you. You talked about the diseased aorta	19	MR. MEADOWS: Show an objection.
:0	here. I notice under the pathology tab that	20	Your question presupposes there is a standard of
!1	there was no pathology. Have you reviewed	21	care.
:2	pathology from the aorta here? Have you had a	22 A.	I think you would need to delineate exactly what
23	chance to go over it?	23	you mean by "disease" and the specific disease
!4 A.	There was gross pathology. There was not	24	process that you are referring to.
:5	microscopic pathology, no.	25 Q.	Do you think calcification played any role with
	Page 25		Page 29
1 0.	Did you review that gross pathology?	1	her diseased aorta that would have caused or
2 A.		2	prompted the dissection?
	What role, if any, did that play, in your		I do not.
4	opinion, as to this being a diseased aorta?	4 Q.	Other than the premise that she must have had
5 A.	The pathology report, as it was issued, did not	5	disease since it dissected, are you able to state
6	describe the aortic wall itself, the character of	6	whether, more likely than not, you were aware of
7	it, to a degree that you would be able to	7	any other pathological condition involving her
8	ascertain whether or not there was disease within	8	aorta which would have caused it to be diseased
9	the media.	9	other than calcification?
10	And microscopically there was nothing done	10 A.	She has atherosclerosis in the aorta. That is
11	to ascertain whether or not there was disease	1	the only pathologic tenet that is described in
12	within the wall of the aorta.	12	the postmortem examination.
13 Q.	Upon what pathologic basis, then, are you	13 Q.	Is that the same as calcification?
14	attributing your opinion that it was diseased, if	-	It may or may not be.
15	not pathology?		Did you review the September 12 films?
16 A.	I am basing it upon the premise that I poke holes		Yes. Heart catheterization?
17	in thousands of aortas every year and don't get	17 Q.	Yes.
18	dissections.	18 A.	Yes, I did.
19	I also do have instances where I have had	19 Q.	Did you find evidence of calcification on the
20	iatrogenic dissections in the operating room.	20	September 12 film?
21	Those patients, by and large, have had diseased	21 A.	Calcification? You would have to be more
22	aortas when we have looked at the aorta	22	specific. Where?
23	pathologically. There is no reason to think that	23 Q.	You read Dr. Nukta's deposition correct?
24	this woman, who had a laceration develop in the	14 A.	Yes.
25	wall of her aorta, would have developed a	25 Q.	And in it he references calcification appearing
			Page 26 - Page 29

Gilbe	rt v. Nukta Mult	i-Page	<sup>TM</sup> Botham, M.D.
	Page 30		Page 32
1	in the September 12 film of the aortic root. Did		That disruption that you just described that
2	you see any of that when you reviewed that film?	2	occurred within anywhere from seconds to minutes,
3 A.	You would have to show me specifically where you	3	do you believe that extended even further between
4	are referring to. There may be calcification in	4	that episode you just described versus at the
5	different areas of the aorta.	5	time of the sternotomy and under direct
6	And I would have to actually, if I am going	6	visualization?
7	to reaffirm his notification of calcification,	7 A.	There is no way to know, because you don't have a
8	actually look at the film either with him or have	8	scan that tells you how much of the entire
9	somebody show me where he feels there is	9	thoracic aorta and abdominal aorta is involved at
0	calcification.	0	the time that the dissection process develops.
1 Q.	You would be unable to do it yourself, then?	1 Q.	Now, would you please describe for me the extent
2 A.	I could show you if you put the film on whether	2	of her dissection, in your opinion.
3	see any calcification in the area, yes.	3 A.	The dissection involved the right coronary sinus
4 Q.	We are going to talk about your expertise in	4	of Valsalva and extended proximally in that sinus
5	interpreting the films in a moment. But as you	5	of Valsalva down to the annulus of the aortic
6	sit here, you don't have any recollection of	6	valve. It then traversed in an antegrade fashion
7	notably seeing calcification in the September 12	7	to involve the entire tubular portion of her
8	film when you reviewed it?	8	ascending aorta up into the transverse aortic
9 A.	If I were to tell you that, I would have to	9	arch.
0	actually look at the film and assure myself that	20 Q.	You mentioned 90 degrees, 280 degrees before.
1	I am, indeed, seeing calcification in the wall of	21	What is your assessment here?
2	the aorta itself.	22 A.	The dissection here evidently involved a fairly
3 Q.	That is fair enough.	23	healthy portion of the circumference of the
4	Have you ever seen a circumferential	24	ascending aorta, as least in terms of how the
5	dissection such as the one in Janice Gilbert?	25	surgeons that are there described it. And that
	Page 3		Page 33
1 <b>A.</b>	Yes.	1	is more the rule than the exception.
	On how many occasions?	2 Q.	Can you describe for me in lay terms what you
3 A.	It depends upon how circumferentially you are	3	mean? In other words, did it go around
4	talking about. I have had them anywhere between	4 A.	Dissection typically spirals as it develops a
5	90 degrees involvement of the aorta to roughly	5	false lumen. It usually starts in a spontaneous
6	280, 290 degrees.	6	dissection along the right lateral wall, and, as
7 Q.	And would you please describe for me your	7	it goes up, to involve the rest of the ascending
8	assessment of the extent of this dissection.	8	aorta posteriorly or spiral anteriorly.
	It was		But this is not a spontaneous dissection,
	At the time we may as well jump right on into	10	correct?
1	it, then. When you first saw evidence of the		It is an iatrogenic dissection.
2	dissection, was it smaller than that as set forth	-	And it is your opinion that, as an iatrogenic
3	in the operative findings by Drs. Woodhall and	13	dissection, it still will spiral in such a
4	VanBergen?	14	fashion?
	No. I think shortly after the dissection process		Yes, that is typical.
6	originated, there was complete involvement of the		More likely than not, correct?
7	entire tubular portion of the ascending aorta as		The dissecting process is the same. The only
8	well as the sinus of Valsalva, which resulted in	18	thing that is different here is the causative factor. The initiating event which is a torr in
9	the aortic insufficiency. Are you able to state more likely than not within	19 20	factor. The initiating event, which is a <b>tear</b> in the intima, is identical.
	what time frame that occurred, that dissection?		Are you able to find angiographic evidence of
21 22 A	Very short time frame.	21 Q. 22	this spiraling dissection, or were you able to?
	Are you able to put a time on that? Seconds?		The only evidence that you see on an <b>angiogram</b> is
23 Q. 24 A.		23 A. 24	the development of the false lumen, and you can
	The worker propagate the within initial of the volume		
24 A. 25	seconds. It is hard to tell.	24	see that. The actual spiraling aspect of it you

Gilbe	rt v. Nukta Multi	Page	TM Botham, M.D
	Page 34		Page 36
1	don't really see unless you are there and you can	1 A.	No. It can if the heart rate is too low. But in
2	look at the aorta on all sides.	2	this instance that is not the issue.
3 Q.	You mean under direct visualization?	3 Q.	It couldn't lower it, then?
	Right.		That's correct.
5 Q.	So it is your belief, then, you said it went down	5 Q.	Procardia, is that a calcium channel blocker?
6	to the annulus of the aortic valve, that would be	-	That is a calcium channel blocker which may lower
7	retrograde, correct?	7	the heart rate as well as the blood pressure.
8 A.	Correct.	8 Q.	Would it be as effective as a beta blocker?
9 Q.	It is your belief that the dissection first	9 A.	It may very well be. It depends on the clinical
0	occurred in retrograde fashion?	0	situation and the response that the patient has.
1 A.	I don't think there is any way you can ascertain	1 Q.	How about if you are trying to lower the heart
2	whether it went retrograde first or antegrade	2	rate of Janice Gilbert in the situation with
3	first. I <i>think</i> it involved the sinus of Valsalva	3	aortic insufficiency and an aortic dissection,
4	originally, probably in a circumferential fashion,	4	which would be more effective, in your opinion?
5	and then traversed retrograde and antegrade with	5 A.	Again, it depends upon the patient's response. I
6	each contraction of the heart.	6	think different patients respond in different
7 Q.	Within seconds to minutes?	7	fashions.
8 A.	Correct.	8	Not infrequently I have patients who I put
9 Q.	Would heart rate have anything to do with that?	9	on calcium channel blockers whose heart rate gets
!0	I am sorry, let me clarify that. Would it just	!0	too low and I have to stop that medication. The
!1	be heart rate, or would blood pressure have a	21	same thing could be said for patients with beta
12	factor on that?	:2	blockers. It really is a variable that you have
!3 A.	It is a combination of both. The most important	!3	to treat a patient and see what the response is
!4	aspect is the force of cardiac contraction, what	14	before you can ascertain which medication they
:5	we call DPDT, the pressure rate constant for	!5	will respond to.
	Page 35		Page 37
1	time. That is the most important aspect in terms	1 Q.	Do you have any reason to believe that either of
2	of a propagation of a dissection.	2	those would not have worked with Janice Gilbert
	There are ways to control the DPDT, correct?	3	in lowering her heart rate?
	Yes.	4 A.	
	Would that be through drug therapy?		You said circumferential tear, and I asked you
	Yes.	6	based upon what you said about 90 and 280
	What type of drugs could you use to control heart	7	degrees, are you able to state, even though you
8	rate?	8	said spiral, give it a number, 360 degrees, or
	Primarily beta blockers, That is the mainstay of	9	whatever, with her dissection?
10	therapy for patients who have aortic dissection.		The tear itself is not circumferential. The tear
	Do you recall whether beta blocker was used here		is a small area that develops in the wall of the
12	with Janice Gilbert? .	12	aorta. Once the blood enters into the false
13 A.	I don't think they did, because her heart rate	13	lumen, then it can spread in a more circumferen-
	was already very well controlled. She had actually	14 15	tial fashion, and it can vary anywhere between 90 and 260 or 280.
15 16 Q.		15 16 Q.	Do you have an opinion, though, as to what that
10 Q. 17	MR. MEADOWS: Wait a minute. Let	10 Q.	number would be, approximately, with Janice
18	him finish his answer. I am not sure he was done	18	Gilbert when it was all said and done?
19	with his answer.		I would have to look at the operative note and
	At least at this point in time they had put a	20	see if Dr. Woodhall and VanBergen describe the
20 A.	pacemaker in so they could control that as well	20	exact involvement circumferentially, how much of
22	as they wanted to, and her hemodynamic parameters	22	the aorta was involved.
23	were actually quite good.		Would you please take a look.
24 Q.			They don't describe specifically how much of the
25 25	rate?	24 A. 25	circumference of the aorta was involved. All
Ľ		25	Page 34 - Page 37

Gilber	t v. Nukta Multi	-Page	<sup>TM</sup> Botham, M.D.
	Page 38		Page 40
1 t	hey describe is that the right coronary artery	1	MR. MEADOWS: Show an objection to
2 a	and the left main coronary arteries were involved	2	the hypothetical as it was phrased.
3 i	n the dissection.	3 Q.	I would next like for you to assume that upon
4 Q. S	So based upon that, you are unable to state the	4	presentation of the aortic dissection it had not
5 e	amounts of circumferential involvement that would	5	extended, as you so described, in spiral fashion;
6 b	e	6	rather, it was localized and did not extend
7 A. ]	That's correct.	7	circumferentially. Fair enough?
8 Q. (	Once that occurred, what, in your opinion, would	8 A.	Is this a hypothetical? Because that was not the
9 t	the risk of mortality in surgery to repair	9	case here.
0 t	hat?	10 Q.	Yes, it is a hypothetical. Would you assume that
I A. I	t is the risk of any mortality for somebody who	11	for me, please.
	has developed an acute aortic dissection. The	12 A.	I <i>think</i> you have to understand that there really
	mortality rate, depending upon the experience of	13	isn't such a thing as a localized dissection. I
	the surgeon, can vary anywhere between 7 and 10	14	think dissections develop and propagate very
	percent to 30 percent.	15	quickly to the point where local repair of a
	So when she presents at 7:30 is when the surgery	16	problem that you feel is a dissection, if it is a
	started with that circumferential dissection all	17	localized problem, is probably that of a hematoma
	the way up through the transverse arch, including	18	rather than a dissection itself.
	the right coronary artery, left coronary artery,		Doctor, have you ever heard of observation of an
	retrograde down through the aortic valve, your	20	aortic dissection?
	opinion is her risk of mortality was 30 percent?		In a Type B dissection, yes. In a Type A
	It depends upon the experience of the surgeon who	22	dissection, no.
	is doing the operative procedure. It can vary		What is the difference between Type <b>A</b> and <b>B</b> ?
	anywhere between 7 to 30 percent, depending upon		Type B dissection originates distal to the origin
	the operating experience.	25	of the left subclavian artery, and a Type $\mathbf{A}$
2 (		2.5	
1 0 1	Page 39		Page
	I would ask you to assume for a moment that		dissection involves the ascending aorta.
	instead of that dissection she went into bypass	-	Have you ever read in the literature that a
	surgery with just the two RCA dissections. What	3	dissection as a result of angioplasty to the
	would be your opinion on risk of mortality with	4	ascending aorta or the junction of the right
	that procedure?	5	coronary artery of the ostium with the aorta,
6	MR. MEADOWS: Objection. You are	6	have you ever read in the literature that that
	asking him to assume there is no aortic	7	was treated conservatively via observation?
	dissection?	8	MR. MEADOWS: Objection.
9	MR. LOUCAS: Correct.		I have never personally read of anybody observing
0	MR. MEADOWS: Objection.	10	an iatrogenic ascending aortic dissection without
	An isolated dissection of coronary artery?	11	operating upon the patient.
2 Q.			Have you any knowledge of a relationship, a
	It depends on whether the patient was hemodynami-	13	proportionate relationship, between the extent of
	cally stable at the time admitted to the	14	a dissection in the aorta and mortality, meaning
	operating room.	15	the longer the dissection, the higher the
	I am talking about Janice Gilbert. Assuming	16	mortality risk?
	there was no aortic dissection, and Dr. Nukta had		There is no question that the more of the aorta
	referred her over to the CT surgeons With just	18	that is involved in aortic dissection process,
	the two tears in the RCA to be repaired, that	19	the greater the mortality is both short-term and
!0	would entail, more likely than not, a right	20	long-term.
!1	coronary bypass, correct?	21 Q.	Would you agree with me that if it is zero to
22 A.	Correct.	22	five millimeters, the risk of mortality is less
13 Q.	Can you tell me what the risk of mortality is	23	than 50 percent?
!4	from that procedure alone?	24 A.	No.
!5 A.	One uercent.	25 Q.	Even assuming it did not extend from that length?
			Page <b>38</b> - Page 41

Page 421 A. I have seen patients who have had very, very limited aortic1 Q. That is fair enough. I want you to assume that2patients who have had very, very limited aortic23 dissections, less than a centimeter or a3centimeter and a half who have exsanguinated from4centimeter and a half who have exsanguinated from45pericardial - or died from pericardial tamponade56due to localized dissection in the ascending67aorta. They are not to be treated medically.78Q. Perforation would have had to have occurred89there, is that correct?99thera's correct.101Q. Do you recall the name of the case that you had11worked on for Bruce Vandevusseup in Detroit?23A. I don't remember the name of34Q. Not the name of the plaintiff or the defendant55physician?166A. That's carrect.167defendant that I was defending, and I don't8remember the name.99Q. Do you know whether any photos were taken of0Janice Gilbert in this case when she went for CT1surgery?2A. I ann unaware of whether or not they took any5bhotographs.6MR. MEADOWS: Do you know of any,7George?1MR. MEADOWS: Do you know of any,2George?3MR. LOUCAS: What is that?4
2patients who have had very, very limited aortic dissections, less than a centimeter or a description additional spectral and the half who have exsanguinated from pericardial or died from pericardial tamponade due to localized dissection in the ascending aorta. They are not to be treated medically.2she just had the two dissections in the right coronary artery, and that she had then been referred over to surgery and it was successful with the right coronary artery bypass.6due to localized dissection in the ascending aorta. They are not to be treated medically.3What is your opinion on what the length of her life would have been to a reasonable degree of medical certainty?8Q. Perforation would have had to have occurred there; is that correct?M. M.EADOWS: Show an objection.0A. That's correct.0You are asking him to take into account all of her other risk factors?1Q. Do you recall the name of the case that you had worked on for Bruce Vandevusse up in Detroit?A. I link you would have to suppose that she would probably live into her 70s.3A. I don't member the name.5Q. Mid-70s?4A. I am unaware of whether or not they took any 5 photographs?1A. I am unaware of whether or not they took any 5 motographs?3M.R. LOUCAS: M.R. MEADOWS:Do you know of any,2Page 434M.R. MEADOWS: M.R. MEADOWS:Do you know of any,5Q. You state in your report5What is that?4M.R. MEADOWS: M.R. MEADOWS:Do you know of any,5Q. You state in your report5
3       dissections, less than a centimeter or a       3       cornary artery, and that she had then been         4       centimeter and a half who have exsanguinated from       5       pericardial or died from pericardial tamponade         6       due to localized dissection in the ascending       6       What is your opinion on what the length of         7       aorta. They are not to be treated medically.       6       What is your opinion on what the length of         8       Q. Perforation would have had to have occurred       8       Of medical certainty?         9       there; is that correct?       9       MR. MEADOWS: Show an objection.         0       A. That's correct.       0       You are asking him to take into account all of         1       Do you recall the name of the case that you had       1       here other risk factors?         2       MR. MEADOWS:       Show an objection.       0         4       Q. Not the name of the plaintiff or the defendant       5       Q. Mid-70s?       1         6       A. No. It was an emergency room physician was the       7       Q. I had asked you a hypothetical, and I am going to         7       Q. Do you know whether any photos were taken of       10       harts operative photographs?       2         3       Q. Yes.       A. I Intraoperative photographs? <t< td=""></t<>
4centimeter and a half who have exsanguinated from pericardial or died from pericardial tamponade due to localized dissection in the ascending a orta. They are not to be treated medically.referred over to surgery and it was successful6due to localized dissection in the ascending a orta. They are not to be treated medically.What is your opinion on what the length of her life would have been to a reasonable degree of medical certainty?8Q. Perforation would have had to have occurred there; is that correct?MR. MEADOWS: Show an objection.0A. That's correct.Vou are asking him to take into account all of ther other risk factors?2Worked on for Bruce Vandevusseu pi n Detroit?A. I don't remember the name of theysician?3A. I don't remember the name of theysician?A. I think you would have to suppose that she would there of the plaintiff or the defendant to physician was the remember the name.MR. MEADOWS: Yes.9Q. Do you know whether any photos were taken of 0 Janice Gilbert in this case when she went for CT surgery?I had asked you a hypothetical, and I am going to a ask you to assume that it is true that at the point she had two RCA dissections, assume that the presentation of the iatrogenic aortic to byiously, differing opinions, so I am going to ask you to assume that it is true that at the point she had two RCA dissections, assume that the presentiation of the iatrogenic aortic to byiously, differing opinions, so I am going to ask you to assume that it is true that at the point she had two RCA dissections, assume that the presentiation of the iatrogenic aortic to surgery have entailed, more likely than not?9MR. MEADOWS: Do yo
5       pericardial or died from pericardial tamponade       5       with the right coronary artery bypass.         6       due to localized dissection in the ascending       6       What is your opinion on what the length of         7       aorta. They are not to be treated medically.       6       What is your opinion on what the length of         8       Q. Perforation would have had to have occurred       9       Mc MEADOWS:       Show an objection.         0       A. That's correct.       0       You are asking him to take into account all of         1       Q. Do you recall the name of the case that you had       1       her other risk factors?         2       Mc Mt and the name of the case that you had       1       her other risk factors?         3       A. I don't remember the name of       2       MR. MEAOWS:       Yes.         4       No. It was an emergency room physician was the       7       Gefendant that I was defending, and I don't       7       Q. Nide-70s?         8       A. I tranoperative photographs?       2       A. I on transport the name.       9       Obyou know whether any photos were taken of       9       disagree with the contents of my hypothetical,         9       Q. Do you know whether or not they took any       5       obviously, differing opinions, so I am going to       ask you to assume that it is true that athe<
6       due to localized dissection in the ascending       6       What is your opinion on what the length of         7       aorta. They are not to be treated medically.       8       Perforation would have had to have occurred       9         8       Q. Perforation would have had to have occurred       9       MR. MEADOWS:       Show an objection.         9       there; is that correct.       0       You are asking him to take into account all of         1       Do you recall the name of the case that you had       1       her other risk factors?         2       MR. MEADOWS:       Show an objection.         4       Q. Not the name of the plaintiff or the defendant       5         5       physician?       3       A. I think you would have to suppose that she would         4       Q. Not the name of the plaintiff or the defendant       5       Q. Mid-70s?         6       A. No. It was an emergency room physician was the       7       Q. I had asked you a hypothetical, and I am going to         8       ask you to assume it. I understand that you       9       Do you know whether any photos were taken of       1         0       Janice Gilbert in this case when she went for CT       1       sak you to assume that it is true that at the         3       Q. Yes.       2       ask you to assume that it is true that at the
7aorta. They are not to be treated medically.7her life would have been to a reasonable degree8Q. Perforation would have had to have occurred9there; is that correct?9MR.MEADOWS: Show an objection.0A. That's correct.9MR.MEADOWS: Show an objection.0You are asking him to take into account all of1Q. Do you recall the name of the plaintiff or the defendant1her other risk factors?2MR. LOUCAS: Yes.3A. I don't remember the name of4A. No. It was an emergency room physician was the6A. No. It was an emergency room physician was the67defendant that I was defending, and I don't7I had asked you a hypothetical, and I am going to8remember the name.9Do you know whether any photos were taken of19Janice Gilbert in this case when she went for CT1obviously, differing opinions, so I am going to1surgery?2ask you to assume that it is true that at the3Q. Yes.2point she had two RCA dissections, assume that4A. I am unaware of whether or not they took any2dissection was localized and did not extend.5Do you know of any,2George?13MR.LOUCAS:Wat is that?34MR.MEADOWS:Do you know of any,15Q. You state in your report5want to make an objection and a motion to strike
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8 Q. Perforation would have had to have occurred       8       of medical certainty?         9       there; is that correct?       9       MR. MEADOWS: Show an objection.         0 A. That's correct.       0       You are asking him to take into account all of         1 Q. Do you recall the name of the case that you had       1       her other risk factors?         2 worked on for Bruce Vandevusse up in Detroit?       3       A. I don't remember the name of         4 Q. Not the name of the plaintiff or the defendant       5       physician?         5 physician?       6       A. No. It was an emergency room physician was the       6         7 defendant that I was defending, and I don't       7       Q. I had asked you a hypothetical, and I am going to         8 wou to assume it. I understand that you       9       Do you know whether any photos were taken of       1         0 Janice Gilbert in this case when she went for CT       1       befacts I am presenting, but there will be,         1 surgery?       2       ask you to assume that it is true that at the         3 Q. Yes.       2       point she had two RCA dissections, assume that         4 A. I am unaware of whether or not they took any       2       dissection was localized and did not extend.         5       photographs.       1       Had she been referred over for surgery at         <
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2worked on for Bruce Vandevusse up in Detroit?2MR. LOUCAS: Yes.3A. I don't remember the name of4A. I don't remember the name of44Q. Not the name of the plaintiff or the defendant5physician?6A. No. It was an emergency room physician was the7Gefendant that I was defending, and I don't57Q. Do you know whether any photos were taken of0Janice Gilbert in this case when she went for CT11surgery?2A. Itraoperative photographs?23Q. Yes.2ask you to assume that it is true that at the3Q. Yes.2ask you to assume that it is true that at the3Q. Yes.2ask you to assume that it is true that at the4MR. MEADOWS: Do you know of any,1Had she been referred over for surgery at2George?2MR. MEADOWS: Do you know of any,13MR. LOUCAS: What is that?4MR. MEADOWS: Do you know of any,14MR. MEADOWS: Do you know of any?5Q. You state in your report55Q. You state in your report5want to make an objection and a motion to strike
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5 Q. You state in your report5want to make an objection and a motion to strike
6 MR. MEADOWS: Let the record 6 that first part in terms of what you expect the
1
3 have well preserved left ventricular function." 13 and answer.
4 You are talking about after her MI, correct? 14 MR. LOUCAS: Fair enough.
5 A. Subsequent to her myocardial infarction and receiving the TPA, yes.15 Q. (Continuing.) Go ahead, Doctor.16 A. I think that the time from when the dissection
7 Q. Do you know what her ejection fraction was? 17 occurred until the time that the patient is 18 occurred until the time that the patient is
8 A. I would have to look at Dr. Nukta's actual 18 actually operated upon, the overwhelming 19 likelihood is that the entire ascending acrta
9 catheterization report. 19 likelihood is that the entire ascending aorta 10 Do you recall whether it was within normal
20Q. Do you recall whether it was within normal20would have been involved, regardless of the time11limits?21frame with which she would have been transported
1
22 A. I would assume that if I wrote down here "well 22 from the cath. lab to the OR.
23 preserved left ventricular function" that she had 23 Given the sequence of events that you are 24 constructing if you are saving she has a limited
14 left ventricular function that was either normal 24 constructing, if you are saying she has a limited
25     or closely thereby.     25     dissection involving the ascending aorta, the       Page 42 - Page 4

Gilbert v.	Nukta Mul	ti-Page	<sup>TM</sup> Botham, M.D.
	Page 4	6	Page 48
1 mair	stay of therapy for that would be to remove,	1	mortality to Janice Gilbert would have been?
2 com	pletely excise, that segment of the ascending	2	MR. MEADOWS: Objection.
3 aorta	that is involved in the dissection process,	3 A.	Well, you would have to patch the aorta. And
4 rega	rdless of the extent that is involved, and	4	then you would have to ligate the aorta at the
5 utiliz	e a Dacron patch or a Dacron tube graft to	5	proximal portion, ligate the right coronary
6 repla	ice that segment of the aorta.	6	artery at its proximal origin from the aorta, and
7 Q. And	assuming further that it occurred at the	7	then do a bypass graft.
	ion of the right coronary artery with the	8	And I don't know that there are any series
9 aorta	a with Janice Gilbert, what would her risk of	9	of patients where that operation has been carried
	ality be with just that procedure and the	0	out so that you can actually state with any
1 right	coronary artery bypass?	1	reasonable degree of certainty as to what the
2	MR. MEADOWS: Objection.	2	mortality rate for that is.
	pends upon whether or not it is an isolated	3 Q.	So you are telling me you don't know of any
	lized dissection to just the ostium of the	4	limited aortic dissection that has been repaired?
Ŭ	coronary artery, or whether there is	5	MR. MEADOWS: No, no, he just said
	ular insufficiency, or whether the dissection	6	he doesn't know that there are studies.
-	propagated in any way, shape or form.	7 A.	That is not what I said, I said there is no
	is a hypothetical case that clearly was	8	series of patients who have undergone limited,
-	present in this case at any point in time,	9	repairable aortic dissection to be able to tell
	I have never been in a situation where I have	20	you with any degree of probability what the
	it, a dissection that is localized like that	21	mortality and morbidity is.
	e ostium of the right coronary artery. So I		How about based on your experience?
	not sure that I could fairly answer that		I have never done an operation such as you are
· ·	tion.	24	talking about. I don't know of any surgeon who
5 Q. Tuno	derstand. It is a hypothetical.	25	has.
	Page 4		Page 49
	Ooctor, I am going to ask you to assume	-	That would mean, then, that your opinion is that
	e set of facts and provide an opinion, if you	2	every aortic dissection extends and just does not
3 are a	able. If you can't give me an opinion, tell	3	remain localized, period, correct?
4 me.			The only time I have ever treated a localized
	am asking you to assume no valvular	5	dissection is when the dissection has occurred to
	ection, just the two dissections in the right	6	me in the operating room and I have literally
	nary artery with an initial onset localized	7	been right there with the chest open and can deal
	ection at the junction of the right coronary	8	with it right at the time it occurs.
	ry with the aorta.	9	And even so, in the overwhelming percentage
	Vith just repair of that, as described, ing else, what is your opinion of the risk of	10	of iatrogenic dissections that develop in the
	tality to Janice Gilbert?		operating room, they are instantaneous and require complete excision of the entire ascending
	-	12	
3 4 alrea	MR. MEADOWS: Object. He has ady answered that, He just answered that.	13 14 Q.	aorta. What is the mortality rate, then, for iatrogenic
	ahead, Doctor.	14 Q.	aortic dissections in your line of work?
6	MR. MEADOWS: Answer it again.		It is the same as would be for somebody who has a
-	repeat what I said, but I am not sure	10 A.	spontaneous dissection. Again, it depends upon
	you saying, then, that you wouldn't be able	18	the degree of involvement of the aorta, of the
	o repair of just that?	19	coronary arteries, of the aortic valve, and
	n't know that there is anybody who has any	20	whether or not there is propagation of the
	stics on that. I don't think that that	21	dissection into the transverse aortic arch and
	ration is ever done.	22	descending thoracic aorta.
1 <b>^</b>	uming, then, that it was just a patch of that	23 Q.	0
	of the aorta with the right coronary artery	20 Q. 24	with your experience or knowledge with dissection
	ass, do you have an opinion what the risk of	25	of the ascending aorta and of the descending
-7P			Page 46 - Page 49

<b>Gilbe</b>	rt v. Nukta Mu	ılti-Page	Botham, M.D.
	Page	50	Page 52
1	aorta that occurs iatrogenically in cardiac	1	believe she needed surgery at that point?
2	catheterization.	2 A.	Yes.
3 <b>A</b> .	The reported series are between 5 and 30	3 0.	What is your opinion as to the urgency or the
4	percent. Some series are actually even a little	4	timeliness that that surgery should have been
5	higher.	5	undertaken?
6 Q.	So it is your opinion, then, that the dissection	6 A.	I think the more expedient you can get a patient
7	occurred within seconds to minutes in antegrade	7	to the operating room to treat an aortic
8	fashion as well as retrograde involving the	8	dissection, the greater the likelihood that you
9	aortic valve and creating insufficiency, correct?	9	will have a successful outcome.
0 <b>A.</b>	Yes.	0 Q.	Did you believe that the conclusion of the
IQ.	And what level insufficiency would you attribute	1	aortogram with assuming successful CT surgery she
2	to that dissection?	2	would have survived, more likely than not?
3 A.	On a scale of 1 to 4-plus, 3 to 4-plus would be	3 <b>A</b> .	Yes.
4	thenumber.	4 Q.	Then how does timeliness come into play? In
5 Q.	And were you able to assess a level of	5	other words
6	insufficiency based on the films that you	6 A.	Well, it does only in one instance, and that
7	reviewed?	7	instance being if while you are waiting to get a
8 A.	Yes.	8	patient to the operating room the aorta
9 Q.	Did you do that at the time you noticed the	9	perforates and you develop cardiac tamponade, and
20	initial dissection, in other words, assess a	20	then you are all of a sudden taking a situation
21	level of 3 to 4?	21	that is relatively well controlled with a
22 A.	No, I think the assessment is made at the time	22	relatively good likelihood of an outcome that is
23	where there is a root injection performed by	23	favorable and turned it into a situation where
24	Dr. Nukta.	24	you have a problem where the outcome is much more
25 Q.	When you say "root injection," are you talking	25	problematic.
	Page	51	Page 53
1	about the aortogram?		Excluding, then, perforation, and we go back to
2 <b>A.</b>	Correct.	2	Janice Gilbert, what is the likelihood that she
3 Q.	So prior to the aortogram, you were not able nor	3	is going to survive?
4	are you able to assess a level of insufficiency	4 A.	Provided they remain hemodynamically stable
5	to her aortic valve, correct?	5	during the interim time period from when the
6 A.	You can ascertain that there is a ortic	6	diagnosis is made and the operative procedure is
7	insufficiency at that time, and you are unable to	7	begun, there really shouldn't be a dramatic
8	ascertain the degree of aortic insufficiency,	8	difference in terms of their likelihood of
9	which is, I suspect, the reason that Dr. Nukta	9	getting a good outcome.
10	went ahead and did an aortogram, so that his	10 Q.	So it doesn't really matter, then, without
11	surgeon would be able to ascertain whether or not	11	perforation, the time, whether she is referred to
12	he needed to do something with the aortic valve.	12	surgery in 15 minutes or three hours?
13 Q.	In your opinion, after reviewing that film, did	13 <b>A</b> .	Once you have developed the dissection, and again
14	the level of aortic insufficiency increase at all	14	it depends a lot upon the degree of involvement
15	during the procedure of September 14 by the time	15	of the aorta, once you have developed the
16	he was done with the aortogram?	16	dissection, provided you don't have ischemia of
17 A.	There is no way to know that because you don't	17	the heart or cerebrovascular insufficiency or
18	have a root injection at another point in time	18	aortic perforation or some other evidence of end
19	and another root injection at another point in	19	organ ischemia, the likelihood of a successful
20	time. You only have one study that is done to	20	outcome should be the same.
21	diagnose the degree of insufficiency in the	21 Q.	
22	aortic valve, and that is the one root injection	22	you get in there, the better?
23	that was done.	23 A.	Well, it is a safer situation to be in an
	At the conclusion of the contempt what is your	0.1	operating room, because if something bad happens,
24 Q.	At the conclusion of the aortogram, what is your	24	you can then put them on bypass immediately.

Gilbert v. Nul	sta Mult	i-Pa	ıge	Botham, M.D.
	Page 54	Ļ		Page 56
	sooner you get in there, the likelihood	1		them back onto the Dacron graft. It maintains
2 is you we	ould have an opportunity to prevent	2		normal continuity. You don't have to put a
3 further ex	stension, if there were going to be	3		bypass graft.
4 further ex		4		For one reason or another, the surgeons who
5 A. It depend	s upon the degree of extension that	5		were there at that time felt that the right
6 there is a	t the time the dissection occurs.	6		coronary artery ostium and the surrounding area,
7 Sometim	es the dissection process extends the	7		which is the button that you, in general, would
	gth of the aorta in a very few	8		take off to sew back on, was unacceptably damaged
	s, so it is totally variable and based	9		from the dissection process to try to reattach it
	patient that you are dealing with.	JD		to the Dacron graft.
	had dissections develop in an	11		Similarly, the left main coronary artery was
	room where I have been standing there	12		involved to the point where they were not
	e entire aorta has dissected within a	13		comfortable reattaching it to the Dacron graft.
	four or five heartbeats.	14	Q.	Are you critical of the care rendered to Janice
	u have an entire dissection involving the	15		Gilbert by the cardiothoracic surgeons?
	e that, what do you expect to be the	1	A.	I am not critical. I probably would have done
7 clinical r	-	17		the operation a little bit differently, but that
8 A. You will	have to be more specific about your	18		is surgeons do operations in different
9 question.		19		fashions.
	s the body respond to a dissection that	20	Q.	It is not your opinion, then, that they rendered
-	he way up the aorta and into the	21		substandard care in their treatment of her; is
	e arch? Hemodynamically, does it react	22		that correct?
	oes the heart rate increase? What do	1		No, it is not.
	ally see with that scenario?		Q.	Is it your opinion that had they done something
5 A. In genera	l terms of the hemodynamics, you will	25		differently, it would have increased or decreased
	Page 5:	5		Page 57
	in the heart rate and a rise in the	1		the likelihood of her survival?
2 blood pre		2	A.	I would have carried the operation out in a
	agree, then, once that occurs the standard	3		different fashion. I have a relatively good
	to keep the heart rate low to prevent	4		track record in dealing with these sorts of
	from extending it even further?	5		problems. The fact that I do it that way is more
	MEADOWS: Once what occurs?	6		of a personal preference than a criticism of
	LOUCAS: An aortic dissection.	7		their attempts to repair the problem they were
	ing.) That the standard of care would be	8		met with.
	se the heart rate so as not to permit		Q.	Would you go ahead and tell me what the
	ng of the heart to extend that	10		difference is, meaning how you would have done it
	n even further?	11		versus the way they did it, in your opinion.
2 A. Yes.			А.	I would probably not have replaced the aortic
	, paragraph one, second sentence, the	13		valve. I probably would have resuspended the
-	t, "The right and left main coronary	14		valve. I probably would have done it under
	vere involved with the dissection and	15		circulatory arrest, so as not to have placed a
	inacceptable for reimplantation."	16		clamp on the aorta.
	did you mean by that?	17		I would have utilized retrograde cerebral
	ry, again, you are asking for which	18		perfusion to perfuse the brain during the period
19 okay.		19		of circulatory arrest.
	paragraph.	20		And then, depending upon how diseased the
	when you are putting in a composite	21		coronary arteries were, I would have either
-	t being a valved conduit, heart valve	22		bypassed them, as they had done, or tried to
	a Dacron tube that comes off of it, the	23	~	reimplant them, as they did not.
	to deal with coronary arteries are to n off as buttons of the aorta and sew		Q.	Resuspending the valve, how would that have
25 take then	n on as outlons of the aorta and sew	25		affected mortality, increased or decreased?

Page 58         Page 60           1         I think you asked him the significance of           valve resuspension worked such to the point where         in think you asked him the significance of           0         What is your opinion as to why the valve could         in the ink you asked him the significance of           0         What is your opinion as to why the valve could         in the res no way for me to know that without           0         A. There is no way for me to know that without         giving cardioplegian a different fashion than           1         the valve pathology.         8         The other things is mould be tased upon what           9         These surgeons felt that at the time when         9         they valve memory the valve was distracted enough         0         It way and had to dcal with at the           10         Are you don?         2         Yes.         2         Yes.           11         There is no way for me to tell you, without         4         actually being in that situation, whether the         4         arcsy you were just takking about had anything           12         valve was wreconstructible or not.         5         4         No, it does not.         5         4         No, it does not.           13         doscribact, valve.         30         in that regard?         7         Why don' you tell ma about	Gilbe	rt v. Nukta Mult	i-Page	<sup>TM</sup> Botham, M.D.
2       valve resuspension worked such to be point where       2       replacing or not replacing the valve in the         3       you wouldn't have had to replace the valve.       3       middle of his answer to your previous question.         4       Wate resuspension worked such to show that valve could       4       A. There are other things in terms of cardioprotes-         5       have been resuspended instead of replaced?       5       tion that 'would be differently, for example, 6         6       A. There is no way for me to know that without       6       which they did.         7       the valve pathology.       8       The other things would be hased upon what         9       These surgeons felt that at the time when       0       the valve mathem what       10       Are you don??         2       repairable valve.       2       A. Yes.       2       Are you don??         10       There is no way for me to tell you, without       3       0. I was going to ask you whether the circulatory         3       actually being in that situation, whether the       3       0. I was going to ask you whether the circulatory         4       actually being in that situation, whether the       3       0. I was going to ask you whether the circulatory         5       walve would be repained have would be repained have would be       inability to administer cardio		Page 58	3	Page 60
3       you wouldn't have had to replace the valve.       3       middle of his answer to your pervious question.         4       Quarties of the stand or replace??       4       There is no way for me to know that without       5         5       A there is no way for me to know that without       6       7       7         6       A. There is no way for me to know that without       6       9       9         7       There serves on fielt that at the time when       9       1       from its supportive structure that it was not a       7       1       A. There is no way for me to tell you, without         6       they were there the valve was distracted enough       7       1       1       1       1       1       4       1       2       A reso         7       There is no way for me to tell you, without       3       1       2       A reso       3       1       1       4       4       4       3       1       4       3       1       4       3       1       1       3       4	1 A.	It would have decreased the mortality had the	1	I think you asked him the significance of
Q. What is your opinion as to why the valve could       4. There are other things in terms of cardioprotection that would do differently, for example,         S. There is no way for me to know that without       a the valve pathology.       5         These surgeons fiel that at the time when       6       the valve pathology.       8         These surgeons fiel that at the time when       9       the valve was distracted enough       9         1 most is supportive structure that it was not a       7       repairable valve.       1         2 repairable valve.       1       2. A resurgeons for me to tell you, without         4 actually being in that situation you are asking me       7       5       10       0 with the method of giving cardioplegia?         6 The hypothetical situation you are asking me       7       5       10. do with the method of giving cardioplegia?         6 A. No, it does not.       7       6       No it does not.       6         7 use would be differently? Ideally, a dario sufficiency, a 3 or 4, as you have       9       wettrice in this case. Do you have an opinion in the regard?         1 Q. Is there any relationship between the level of ansufficient due to a dissection are that insufficient due to a dissection are that is a ropaired.       1       0. When is your curiticism of tha	2	valve resuspension worked such to the point where	2	replacing or not replacing the valve in the
5       have been resuspended instead of replaced?       5       tion that 1 would do differently, for example,         6       A. There is no way for me to know that without       6       giving cardioplegian a different fashion than         8       the valve pathology.       7       The other things would be based upon what         9       These surgeons folt that at the time when       9       they were there the valve was distracted enough         1       from its supportive structure that it was not a       1       Q. Are you done?         3       There is no way for me to tell you, without       3       Q. I was going to ask you whether the circulatory         4       actually being in that situation, whether the       4       arresty you were just talking about had anything         5       valve would be repairable and we would be       5       to do with the method of giving cardioplegia?         6       The hypothetical situation you are asking me       5       to do with the method of giving cardioplegia to the right         7       Use would be repairable and we would be       8       inability to administer cardioplegia to the right         9       abeto resurgend it and be able to retain a       9       ventrick in this case. Do you have an opinion         10       in that regard?       1       A       Nhe I do cardias surgery, Vinually 100 percent <td>3</td> <td>you wouldn't have had to replace the valve.</td> <td>3</td> <td>middle of his answer to your previous question.</td>	3	you wouldn't have had to replace the valve.	3	middle of his answer to your previous question.
6 A. There is no way for me to know that without       6       giving cardioplegiain a different fashion than         7       actually being there at the time and looking at       6       giving cardioplegiain a different fashion than         9       These surgeons felt that at the time when       9       the valve pathology.       8       The other things would be based upon what         9       These is no way for me to tell you, without       4       attually being in that situation, whether the       1       Q       Are you done?       2       N       Yes.         5       valve was distraction you are asking me       5       to do with the method of giving cardioplegia?       6       N. No. it does not.       5       to do with the method of giving cardioplegia to the right         9       able to resuspend it and be able to retain a       0       competent valve.       7       Why don't you tell me about the ability or         12       C. Is there any relationship between the level of       1       A. No. it does and       1       I. A ment 1 do cardiac surgery. Virtually 100 percent         13       described, to the degree of damage to the aortic       1       A. Mort 1 do cardiac surgeons who use antegrade cardioplegia at all. It is,         1       insufficient solely because they have lost the       1       1       A. They utilized antegrade cardioplegia, <t< td=""><td>4 Q.</td><td>What is your opinion as to why the valve could</td><td>4 A.</td><td>There are other things in terms of cardioprotec-</td></t<>	4 Q.	What is your opinion as to why the valve could	4 A.	There are other things in terms of cardioprotec-
2       actually being there at the time and looking at       7       which they did       7         8       the valve pathology.       7       which they did       7         9       These surgeons felt that at the time when       9       These surgeons felt that at the time when       9       they actually saw and had to deal with at the         0       they were there the valve was distracted enough       10       The typ dictical structure that it was not a       2       A Yes.         3       There is no way for me to tell you, without       3       Q. I was going to ask you whether the circulatory         4       actually being in that situation, whether the       2       A. Yes.       3       Q. I was going to ask you whether the circulatory         3       walve was reconstructible or not.       3       Q. I was going to ask you whether the circulatory         4       arrest you were just talking about had anything       5       to with the method of giving cardioplegin?         6       A. No vere would be repairable and we would be       6       No. I does not.       7         9       white on the cast of a sy ou have       10       in that regard?       11       A. When I do cardiae surgery, Virually 100 percent         15       A No. Very frequently valves that are this       12       6       1       11	5	have been resuspended instead of replaced?	5	tion that I would do differently, for example,
8       the valve pathology.       8       The other things would be based upon what         9       These surgeons fielt that at the time when       1       from its supportive structure that it was not a         1       from its supportive structure that it was not a       1       Q. Are you done?         2       repairable valve.       1       Q. Are you done?         3       There is no way for me to tell you, without       3       0. I was going to ask you whether the circulatory         4       actually being in that situation, whether the       2       A. Yes.         5       valve was reconstructible or not.       5       to with the method of giving cardioplegia?         6       The hypothetical situation you are asking me       7       O. I was going to ask you whether the circulatory         6       arcsi yrou were just talking about had anything       5       to with the method of giving cardioplegia?         7       the valve would be repairable and we would be       7       O. Why don't you tell me about the ability or         8       insufficient valve.       1       A. They tergard?       I think, a safer way to deliver cardioplegia to the right         9       uartice in this case.       Do you have an opinion       in the time?       do this method cardioplegia to the right         12       oardi give antegrade c	6 A.	There is no way for me to know that without	6	giving cardioplegia in a different fashion than
9       These surgeons felt that at the time when       9       they actually saw and had to deal with at the         0       they were there the valve was distracted enough       intend they did their procedure.         1       from its supportive structure that it was not a       0       I was going to askyou whether the circulatory         2       actually being in that situation, whether the       0       I was going to askyou whether the circulatory         5       valve was reconstructible or not.       0       I was going to askyou whether the circulatory         7       is: How would I do this differently? Ideally,       6       No, it does not.       0         9       able to resuspend it and be able to retain a       0       valve would be repairable and we would be       8         10       competent valve.       10       inability to administer cardioplegia to the right         11       able to resuspend it and be able to retain a       0       valve?       14         12       as the cardificient, als 2 of the time 1 used cardioplegia to       15       15       No. Very frequently valves that are this       12       off time used resurgend it and.       14         13       described, to the degree of damage to the aortic       13       don't give antegrade cardioplegia,       1       1         14       valve?	7	actually being there at the time and looking at	7	which they did.
0       they were there the valve was distracted enough       0       time that they did their procedure.         1       from its supportive structure that it was not a       1       Q       Are you done?         3       There is no way for me to tell you, without       3       Q       I was going to ask you whether the circulatory         4       actually being in that situation, whether the       3       Q       I was going to ask you whether the circulatory         6       The hypothetical situation you are asking me       7       N by do y you tell me about the ability or         8       the valve would be repairable and we would be       8       inability to administer cardioplegia to the right         9       able to resuspend it and be able to retain a       9       ventrick in this case. Do you have an opinion         10       competent valve.       10       A       When I do cardiac surgery. Virtually 100 percent         12       aorits sufficiency, a 3 or 4, as you have       12       dort give antegrade cardioplegia to       1         14       valve?       12       dort give antegrade cardioplegia to       1         15       A No. Very frequently valves that are this       15       dort give antegrade cardioplegia.       1         15       A No. Very frequently valves that are this       15       and a more u	8	the valve pathology.	8	The other things would be based upon what
1       G. Are you done?         2       repairable valve.       2         3       There is no way for me to tell you, without       3       Q. I was going to ask you whether the circulatory         4       actually being in that situation, whether the       3       Q. I was going to ask you whether the circulatory         5       valve was reconstructible or not.       5       6       N. No, it does not.         7       is: How would I do this differently? Ideally,       6       N. No, it does not.         8       the valve would be repairable and we would be able to resuspend it and be able to retain a       9       competent valve.       10       whon it doe andits         9       Q. Is there any relationship between the level of       11       A. When I do cardiac surgery, Virtually 100 percent         12       a trick using the valve or gluing the       14       When I do cardiac surgery, Virtually 100 percent         13       described, to the degree of annage to the aortic       14       A. When I do cardiac surgery. Virtually 100 percent         15       A. No. Very frequently valves that are this       25       the heart, and results in a more uniform protection.         14       insufficient due to a dissection are that       1       and a more uniform protection.         15       A. No erepaired.       3       They util	9	These surgeons felt that at the time when	9	they actually saw and had to deal with at the
2       repairable valve.       2       A. Yes.         3       There is no way for me to tell you, without       4       actually being in that situation, whether the         5       valve was reconstructible or not.       5       to do with the method of giving cardioplegia?         6       The hypothetical situation you are asking me       7       Why don't you tell me about the ability or         7       W by don't you tell me about the ability or       inability to administer cardioplegia to the right         9       able to resuspend it and be able to retain a       9       ventricle in this case. Do you have an opinion         9       able to resuspend it and be able to retain a       9       ventricle in this case. Do you have an opinion         10       competent valve.       1       A. When I do cardiac surgery, Virtually 100 percent         12       oartic sufficiency, a 3 or 4, as you have       1       A. When I do cardiac surgery, Virtually 100 percent         12       oartie sufficient due to a dissection are that       1       and a more uniform protection.         1       insufficient due to a dissection are that       1       and a more uniform protection.         2       What is your criticism of that, if any?       5       A. They utilized antegrade cardioplegia.         2       Q. Wina did they do here?       3       A	0	they were there the valve was distracted enough	0	time that they did their procedure.
3       Q. I was going to ask you whether the circulatory         4       actually being in that situation, whether the       3       Q. I was going to ask you whether the circulatory         4       actually being in that situation, whether the       3       Q. I was going to ask you whether the circulatory         6       The hypothetical situation you are asking me       7       S. No, was reconstructible or not.       6         6       The hypothetical situation you are asking me       7       O. Why don't you tell me about the ability or         7       be very work we would be repairable and we would be       9       vortricle in this case. Do you have an opinion         9       optic term y relationship between the level of       9       vortricle in this case. Do you have an opinion         10       competent valve.       1       and a regard?       1         12       aorits sufficiency, a 3 or 4, as you have       15       described, to the degree of damage to the aoritic       3       don't give antegrade cardioplegia at 11       15         1       nasufficient solely because they have lost the       1       and a more uniform protection.       1         2       What di they do here?       2       What is your criticism of that, if an?       5         3       supportive structure, the commissure of the       3       A	1	from its supportive structure that it was not a	1 Q.	Are you done?
4       actually being in that situation, whether the       4       arrest you were just talking about had anything         5       valve was reconstructible or not.       6       A. No, it does not.         7       is: How would I do this differently? Ideally,       6       A. No, it does not.         8       inability to administer cardioplegia to the right         9       able to resuspend it and be able to retain a       9       ventricle in this case. Do you have an opinion         10       competent valve.       10       in that regard?       11         12       Is there any relationship between the level of       12       of the time Luesd retrograde cardioplegia a I.       11         2       of the time Luesd retrograde cardioplegia to the activity valve?       14       14       this, a safer way to deliver cardioplegia to the heart, and results in a more uniform protection.         2       walve.       20       What did they do here?       20       What did they do here?         3       and a more uniform protection.       20       What did they do here?       3       A. They utilized antegrade cardioplegia.         4       valve.       3       A. They utilized antegrade cardioplegia.       4       2       What did they do here?       3       A. They utilized antegrade cardioplegia.       4       4       4	2	repairable valve.	2 A.	Yes.
5       valve was reconstructible or not.       5       to do with the method of giving cardioplegia?         6       A. No, it does not.       7         7       is: How would 1 do this differently? Ideally,       7         8       the valve would be repairable and we would be       7         9       able to resuspend it and be able to retain a       9         9       outpett valve.       10         11       Q. Is there any relationship between the level of       11         12       aortic sufficiency, a 3 or 4, as you have       12         13       described, to the degree of damage to the aortic       13         14       valve?       11         15       A. No. Very frequently valves that are this       12         14       insufficient due to a dissection are that       1         1       insufficient solely because they have lost the       2         3       supportive structure, the commissure of the       2         4       valve.       2         5       And resuspending the valve ore gluing the         6       walls of the aorta back together can result in         7       complete competency of the valve once it is         8       repaired.       8         9       Q.	3	There is no way for me to tell you, without	3 Q.	I was going to ask you whether the circulatory
6       The hypothetical situation you are asking me       6       A. No, it does not.         7       is: How would I do this differently? I deally,       inability to administer cardioplegia to the right         9       able to resuspend it and be able to retain a       9         9       able to resuspend it and be able to retain a       9         10       competent valve.       10         11       Q. Is there any relationship between the level of       11         12       aortic sufficiency, a 3 or 4, as you have       12         12       aortic sufficiency, a 3 or 4, as you have       12         13       described, to the degree of damage to the aortic       13         14       valve?       14         15       A. No. Very frequently valves that are this       15         15       No. Very frequently valves that are this       15         16       assupportive structure, the commissure of the       20         11       insufficient solely because they have orgluing the       20         6       walls of the aorta back together can result in       6         7       complete competency of the valve orgluing the       6         6       walls of the aorta back together can result in       6         7       complete competency of the v	4	actually being in that situation, whether the	4	arrest you were just talking about had anything
7       is: How would I do this differently? Ideally,       7       0. Why don't you tell me about the ability or         8       the valve would be repairable and we would be       8       inability to administer cardioplegia to the right         9       able to resuspend it and be able to retain a       9       ventricle in this case. Do you have an opinion         10       12       betto resuspend it and be able to retain a       9       ventricle in this case. Do you have an opinion         12       astribut of the degree of damage to the aortic       11       A. When I do cardiac surgery, Virtually 100 percent         12       off the time I used retrograde cardioplegia at all. It is,       11       A. When I do cardiac surgery, Virtually 100 percent         12       off the time I used retrograde cardioplegia at all. It is,       14       A. When I do cardiac surgery, Virtually 100 percent         13       don't give antegrade cardioplegia at all. It is,       14       I think, a safer way to deliver cardioplegia to         15       insufficient due to a dissection are that       1       and a more uniform protection.         2       What did they do here?       3       A. They utilized antegrade cardioplegia.         3       repaired.       3       A. They utilized antegrade cardioplegia, and there are some         10       mortality, increase or decrease?       7	5	valve was reconstructible or not.	5	to do with the method of giving cardioplegia?
8       the valve would be repairable and we would be       8       inability to administer cardioplegia to the right         9       able to resuspend it and be able to retain a       9       ventricle in this case. Do you have an opinion         10       competent valve.       10       in that regard?         11       L Is there any relationship between the level of       11       A. When I do cardiac surgery, Virtually 100 percent         12       aortic sufficiency, a 3 or 4, as you have       12       of the time I used retrograde cardioplegia at all. It is,         13       described, to the degree of damage to the aortic       13       don't give antegrade cardioplegia to the right         14       valve?       14       the heart, and results in a more uniform protection.       1         15       h. No. Very frequently valves that are this       12       and a more uniform protection.       2         2       insufficient ole to a dissection are that       1       and a more uniform protection.       2       0         2       supportive structure, the commissure of the       3       A. They utilized antegrade cardioplegia.       4       Q. What is your criticism of that, if any?         5       And resuspending the valve or gluing the       5       A. It is a different manner in which surgeons give       6       cardioplegia. There is a significant number of	6	The hypothetical situation you are asking me	6 A.	No, it does not.
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90       competent valve.       90       in that regard?         11 Q. Is there any relationship between the level of a ortic sufficiency, a 3 or 4, as you have       11 A. When I do cardiac surgery, Virtually 100 percent 20         12       a ortic sufficiency, a 3 or 4, as you have       12       of the time I used retrograde cardioplegia t all. It is, 4         13       described, to the degree of damage to the aortic 21       is described, to the degree of damage to the aortic 22       of the time I used retrograde cardioplegia to 23         25       A. No. Very frequently valves that are this       12       of the time I used retrograde cardioplegia to 25         26       Page 55       Page 61         1       insufficient solely because they have lost the 2       and a more uniform protection.         2       Q. What did they do here?       3         3       supportive structure, the commissure of the 4       valve.       4         4       valve.       4       Q. What is grour criticism of that, if an?         5       And resuspending the valve once it is 8       repaired.       8       and there is a significant number of surgeons who 9       9         9       Q. Circulatory arrest, how would that have affected 9       9       use retrograde cardioplegia, and there are some 9       10       who use both.         11       A. It is a safer way to constr	8	the valve would be repairable and we would be	8	inability to administer cardioplegia to the right
11       Q. Is there any relationship between the level of       11       A. When I do cardiac surgery, Virtually 100 percent         12       aortic sufficiency, a 3 or 4, as you have       12       of the time I used retrograde cardioplegia 1         13       described, to the degree of damage to the aortic       13       don't give antegrade cardioplegia at all. It is,         14       valve?       14       I think, a safer way to deliver cardioplegia to         15       A. No. Very frequently valves that are this       15       the heart, and results in a more uniform protection.         2       insufficient due to a dissection are that       1       and a more uniform protection.         2       insufficient solely because they have lost the       3       A. They utilized antegrade cardioplegia.         4       valve.       2       Q. What is your criticism of that, if any?         5       And resurgending the valve or gluing the       6       cardioplegia.         6       walls of the aorta back together can result in       6       cardioplegia.         7       complete competency of the valve once it is       7       cardioplegia, and there are some         10       mortality, increase or decrease?       10       What is a safer way to construct the distal         12       procodure.       13       A. I are not exactly sure	9	able to resuspend it and be able to retain a	9	ventricle in this case. Do you have an opinion
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13       described, to the degree of damage to the aortic       13       don't give antegrade cardioplegia at all. It is,         14       valve?       14       I think, a safer way to deliver cardioplegia to         15       A. No. Very frequently valves that are this       15       the heart, and results in a more uniform cooling         15       and a more uniform protection.       2       Q. What did they do here?       3         3       supportive structure, the commissure of the       2       Q. What is your criticism of that, if any?         5       An resuspending the valve or gluing the       5       A. They utilized antegrade cardioplegia.         4       valve.       3       A. They utilized antegrade cardioplegia.         5       And resuspending the valve or gluing the       5       A. It is a different manner in which surgeons give         6       cardiafor grade cardioplegia, and there are is a sery high percentage of       7       cardiac surgeons who use antegrade cardioplegia, and there are some         9       Q. Circulatory arrest, how would that have affected       9       use retrograde cardioplegia, and there are some         11       A. It decreases the operative mortality of this       11       Q. Did it make any difference in her outcome that         12       procedure.       13       A. I am not exactly sure that there was a difference.     <	!1 Q.	Is there any relationship between the level of	21 A.	When I do cardiac surgery, Virtually 100 percent
14valve?14I think, a safer way to deliver cardioplegia to the heart, and results in a more uniform cooling15A. No. Very frequently valves that are this1Page 551insufficient due to a dissection are that1and a more uniform protection.2insufficient solely because they have lost the supportive structure, the commissure of the valve.2What did they do here?3supportive structure, the commissure of the valve.3A. They utilized antegrade cardioplegia.4valve.4Q. What is your criticism of that, if any?5And resuspending the valve or gluing the omplete competency of the valve once it is mortality, increase or decrease?5A. It is a different manner in which surgeons give cardioplegia. There is a very high percentage of cardioplegia, and there are some use retrograde cardioplegia, and there are some use retrograde cardioplegia was delivered.14A. It is a safer way to construct the distal santomosis. It allows you to actually look into the ther any out have involvement and how much involvement you have. It allows you to perform transverse aortic arch, and allows you to perform transverse aortic arch, and allows you to perform tansverse aortic arch, and allows you to perform tansverse aortic arch, and allows you to perform tansverse aortic arch, and allows you topefform	2!	aortic sufficiency, a 3 or 4, as you have	2!	of the time I used retrograde cardioplegia. I
15       A. No. Very frequently values that are this       15       the heart, and results in a more uniform cooling         Page 51       Page 51       Page 51       Page 61         1       insufficient due to a dissection are that       1       and a more uniform protection.       Page 61         2       insufficient solely because they have lost the       2       Q. What did they do here?       3         3       supportive structure, the commissure of the       3       A. They utilized antegrade cardioplegia.         4       valve.       3       A. They utilized antegrade cardioplegia.         5       And resuspending the valve or gluing the       5       A. It is a different manner in which surgeons give         6       walls of the aorta back together can result in       6       cardioplegia. There is a very high percentage of         7       complete competency of the valve once it is       7       cardiac surgeons who use antegrade cardioplegia,         8       repaired.       9       Q. Circulatory arrest, how would that have affected       9       use retrograde cardioplegia, and there are some         10       mortality, increase or decrease?       10       who use both.       11       Q. Did it make any difference in her outcome that         12       procedure.       13       A. It an not exactly sure that there was a	23	described, to the degree of damage to the aortic	23	don't give antegrade cardioplegia at all. It is,
Page 55Page 611insufficient due to a dissection are thatand a more uniform protection.2insufficient solely because they have lost theand a more uniform protection.3insufficient solely because they have lost theand a more uniform protection.3unilized antegrade cardioplegia.4valve.And resuspending the valve or gluing the5And resuspending the valve or gluing theAnd resuspending the valve or gluing the6walls of the aorta back together can result in7complete competency of the valve once it is8repaired.9Q. Circulatory arrest, how would that have affected10mortality, increase or decrease?11A. It decreases the operative mortality of this12procedure.13Q. Why would you have done that?14A. It is a safer way to construct the distal15anastomosis. It allows you to accutally look into16the transverse aortic arch to ascertain whether17or not you have involvement and how much18involvement you have. It allows you to perform12MR.MEADOWS: Were you through23with your earlier answer to the question as to if24there was anything else you would have done25MR.MEADOWS: Were you through26with your earlier answer to the question as to if27there was anything else you would have done28differently?29Were they able to administer cardioplegia in the <t< td=""><td>24</td><td>valve?</td><td>24</td><td>I think, a safer way to deliver cardioplegia to</td></t<>	24	valve?	24	I think, a safer way to deliver cardioplegia to
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10mortality, increase or decrease?10who use both.11A. It decreases the operative mortality of this11Q. Did it make any difference in her outcome that12procedure.11Q. Did it make any difference in her outcome that13Q. Why would you have done that?13A. I am not exactly sure that there was a difference.14A. It is a safer way to construct the distal13A. I am not exactly sure that there was a difference.15anastomosis. It allows you to actually look into15outcome was affected by the manner in which16the transverse aortic arch to ascertain whether16cardioplegia was delivered.17or not you have involvement and how much17I think what you can say is that there are18involvement you have. It allows you to ascertain19have resulted in better protection to the right20transverse aortic arch, and allows you to perform20coronary and right ventricular chamber. But,21a tension-free anastomosis in a bloodless field.22Q. Were they able to administer cardioplegia to the23with your earlier answer to the question as to if23right ventricle?24there was anything else you would have done25left main coronary artery, but not in the right.	8	repaired.	8	and there is a significant number of surgeons who
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	25	differently?	25	· · · · · · · · · · · · · · · · · · ·

Gilbe	rt v. Nukta Multi	-Page	<b>Botham, M.D.</b>
	Page 62		Page 64
1 Q.	And the significance of that?	1	inadequate protection of the heart. Cardioplegia
2 A.	It depends upon the amount of cardioplegia that	2	can develop as a result of a problem on the left
3	they administered, and it depends upon the amount	3	side of the heart. There are a number of things
4	of collateral flow you have from the left-sided	4	that can cause right ventricular failure.
5	vessels to the right-sided vessels.	5 Q.	What do you think caused it here?
6	Sometimes if you give a healthy dose of	-	I don't think there is any way to ascertain that
7	cardioplegia just through the left side it will	7	because we didn't really get an intraoperative
8	percolate around through the collateral systems	8	transesophageal echocardiogram to look at the
9	into the right coronary system and basically	9	right ventricular chamber to ascertain whether or
0	protect the right ventricle, as well as the	0	not it was indeed stunned or whether or not there
1	inferior wall of the right and left ventricle	1	was actually an infarction process going on. We
2	that would ordinarily be taken care of by a right	2	don't know exactly what caused her right
3	coronary injection.	3	ventricular failure.
4 Q.	Do you know if she was right-side dominant?	4 Q.	Did you find any evidence of an infarct?
5 A.	I believe she was right-side dominant.	5 A.	There is nothing that is stipulated specifically
6 Q.	Are you aware of the extent of collateralization	6	in the operative note itself. All it talks about
7	of blood supply between the two systems with	7	is the right ventricle not pumping in an adequate
8	Janice Gilbert?	8	fashion.
9 A.	In her case the left-sided injection did not	9	There are a number of things that you can do
0	really result in a lot of fill of the right	0	when you are in the operating room to ascertain
1	coronary artery.	1	what exactly the problem is with getting somebody
2 Q.	What is the relationship of what you are talking	2	off bypass.
3	about with this cardioplegia to an infarct, a	3	I think most important is to use a
:4	ventricular infarct?	4	transesophageal echocardiogram to actually look
5 A.	Well, you can have an infarct from a number of	5	at all the chambers of the heart to see which
	Page 63		Page 65
1	things. By and large, an infarction develops	1	chambers are beating and which are not. That
2	when you have an absence of antegrade flow down a		then allows you to treat the patient in an
3	coronary artery for one reason or another.	3	appropriate fashion.
	I am basically asking you I am going to bare		Addressing the area of more timely importance?
5	my ignorance here, because I have heard		What it does is allows you to assess which
6	"ventricular infarction," and I have no idea	6	portion of the heart is not functioning in an
7	what we are talking about here.	7	adequate fashion such that it will allow you to
	Infarction is the end stage process in an	8	separate the patient from bypass.
9	ischemic event. When you occlude somebody's		When you say antegrade flow, which direction is
0	coronary artery, they develop ischemia. And as	0	that?
	that ischemia progresses with time, the muscle becomes more and more'ischemic to the point where		That is in a normal anatomic pathway.
2	the muscle cells themselves become nonviable and		Was it your opinion that it was a ventricular infarction that did her in? I know I heard that
גז 14	die. That is the process when you then develop	3	
5	an infarction.	4	someplace. There is no way to know whether there was
5 16 Q.	~	5 A. 6	ventricular infarction or whether the ventricle
10 Q.	Janice Gilbert?	7	itself was stunned.
	Right ventricular failure.		Is it your opinion that this would have been the
	Is that unusual? Is that something you did not	8 Q. 9	end result, regardless of the extent of
20	expect to see in a case like this?	9 !0	dissection, with this patient going into CT
	I think it is one of the it is a complication	21	surgery?
22	of any open heart surgical procedure. It can		
23	develop as a result of a multitude of different	12 A.	complication that developed <b>as</b> a result of the
24	things, be it ischemia, in other words, not	24	operative procedure. Does it happen? Yes, it
25	enough fluid, or it can develop as a result of	25	happens.
	enough mana, or it can develop as a result of	· · ·	Daga 62 - Daga 65

Gilbe	rt v. Nukta Mu	lt	Page	<b>Botham, M.D.</b>
	Page	66		Page 68
1 Q.	Doctor, you say "It is the force of cardiac		1	utilized in a situation like this that was
2	contraction along with the intraluminal pressure		2	happening with respect to Janice Gilbert?
3	that results in the propagation of the			I think the most expedient manner to diagnose the
4	dissection, not the instrumentation."		4	dissection was that which was undertaken, and in
5	Are you saying that instrumentation can		5	this case it was an aortogram.
6	never propagate a dissection, extend it?			Why do you say the most expedient?
7 A.	Instrumentation is the etiologic agent that		7 A.	Because the patient was in a catheterization
8	allows for the dissection to develop. The		8	laboratory with a catheter in the aorta. It was
9	propagation of the dissection is the result of		9	a matter of injection of the ascending aorta to
0	the force of the cardiac contraction and the		0	confirm the diagnosis and ascertain the degree of
1	pressure with the lumen of the organ. It is in		1	aortic insufficiency.
2	every instance, whether it is spontaneous or		2 Q.	Actually what you are worried about then in
3	iatrogenic.		3	timeliness with regard to getting her into the
4 Q.	That is assuming that it takes the path that		4	hands of CT surgeons on an emergent basis is the
5	you have so described, meaning that it is		5	level of insufficiency, not the extent of the
6	instantaneous and extended?		6	dissection?
7 A.	Regardless, you have to have an etiologic factor		7 A.	Well, you want to know the extent of the
8	that allows blood to enter the media of the		8	dissection, as well.
9	aorta. That then becomes separate from the		9 Q.	Why is that?
:0	dissection process, which is that which develops		0 <b>A.</b>	Because it will tailor or make you tailor your
:1	after the etiologic process begins.		1	operative procedure in one way, shape or form.
:2 Q.	Do you consider contrast material to be an		2 Q.	And it perhaps may increase or decrease mortality
:3	extension of instrumentality, in other words,		3	on that basis?
:4	contrast material being forced into that lumen,		4 A.	Depending upon whether or not you have
:5	that false lumen, could act the same as the blood		5	involvement of the valve with insufficiency or
	Page	67		Page 69
1	flow in causing a propagation of a dissection,		1	whether or not you have a localized dissection
2	correct?		2	that involves just the ascending aorta and not
3	MR. MEADOWS: Objection.		3	the transverse arch.
4	MR. TREU: Objection.		4 Q.	Of the three that you mentioned, and you have
5 A.	I think any time you have fluid in a false lumen		5	mentioned "the most expedient," which is the most
6	where there is communication between a true and		6	expedient?
7	false lumen, be it either contrast material or		7 <b>A.</b>	In this case, not in all cases the majority of
8	blood, which in this case were admixed, the		8	cases, the most expedient way to diagnose these
9	actual presence of the contrast material has		9	is either to be by CT scan or transesophageal
0	nothing to do with the propagation of the		0	echocardiography. But that. Again is in a
1	dissection.		1	situation where you are having a spontaneous
2	The dissection is propagated by the beating		2	dissection not an iatrogenic dissection.
3	of the heart and the pressure on the wall.			, I J
14 Q.	•		4	aortography. However, he could have used one of
5	hyperosmolar or not in Janice Gilbert?		5	the other two, as well?
	Most contrast material is hyperosmolar. But			There was no reason to.
17	there is so much mixing between the true and			But the question was: He could have, however?
18	false lumen that the degree of hyperosmolarity		8	MR. MEADOWS: Objection.
19	within the false lumen at any one point in time			He could have, but it would probably have been a
20	is very, very small.		10	deviation from the standard of care in the fact
	Do you know what the hyperosmolality is of		!1	that he already had a catheter in the ascending
22	Optiray?		!2	aorta. There is no reason not to do the most
	I do not.		:3	expedient test to make the diagnosis. And that
24 Q.	Doctor, you talked about three ways to diagnose		!4	would be aortography.
25	an aortic dissection. Arc any of these three		13 Q.	Which one is the most accurate in terms of

Gilbe	rt v. Nukta Mult	i-Page	TM Botham, M.D.
	Page 70		Page 72
1	identifying the dissection or the extent of the	1 Q.	Level II surgery, it said in the records at
2	dissection?	2	Fairview when he undertook the angioplasty. What
3 A.	I think that each type of modality has its	3	is a Level II procedure? Do you have any idea
4	benefits and pluses and minuses in terms of what	4	what that is or what that means?
5	it will tell you about a patient who has an	5 A.	Usually at a PTCA that is done. A Level III is
6	aortic dissection.	6	one where you have an operating room available
7	The gold standard by which all other methods	7	and a surgeon available at that time to take care
8	are compared against remains aortography. The	8	of whatever problem might arise.
9	problem is in spontaneous dissections it is not	9	A Level II angioplasty is that you have a
0	the most expedient.	0	surgeon who is available within a half an hour or
1	Clinicians have had a tendency over the last	1	45 minutes of the hospital, and that you have the
2	few years to move more towards utilizing CT	2	facility by which to undertake an operative
3	scanning or transesophageal echocardiography	3	procedure should one be necessary in a reasonable
4	simply because they can get an answer very, very	4	facile fashion.
5	quickly.	5 Q.	So the half hour to 45 minutes means what, that
6 Q.		6	the surgeon just has to be on the property within
7	options, which one would be more accurate in	7	half an hour or 45 minutes?
8	defining the extent of the dissection with	8 A.	That he Will be able to consult within a half an
9	somebody like Janice Gilbert?	9	hour or 45 minutes.
0	MR. MEADOWS: Asked and answered.	20 Q.	So it doesn't mean that the standby team should
1	Objection.	21	be able to begin surgery within 45 minutes?
2 A.	The most accurate, I feel, test to give a cardiac		No. It is very rare that even in emergent
3	surgeon the most information that they can get is	23	situations that you are actually able to
4	a transesophageal echocardiogram.	24	immobilize a team and physically have the
5 Q.	What is the significance of the pulmonary	25	operating room set up such that you are able to
	Page 71		Page 73
1	arterial pressure recorded at 36 over 22. You	1	transport the patient from Point A to Point B and
2	mentioned that specifically.	2	start the operative procedure at that time.
3 A.	Well, I think that it tells you at the time that	3 Q.	Let's take a look at that film, Doctor, and then
4	the patient presented to the operating room that,	4	we can finish up.
5	from a cardiac contractility standpoint, she was	5 A.	All right.
6	in relatively good shape. She didn't have any	6	MR. LOUCAS: What I suggest, Bill,
7	significant ischemia involving either of the	7	is that we go ahead and put the tape in, and I
8	coronary arteries; that she didn't have any	8	will go ahead and direct it to where I want to
9	evidence of cardiac tamponade, as evidenced by	9	look, and you can size up the cine. film at the
0	the fact that her pressures were relatively	10	same location for clarity.
1	normal, along with her hemodynamic parameters at	11	(Thereupon, a short recess was taken, and
2	the time that she entered the operating room.	12	Richard Vadnal, Esq. has left the conference
3	(Thereupon, Kris Treu, Esq. leaves the	13	room.)
4	conference room.)	14 Q.	(Continuing.) Doctor, as we begin to look at
5 Q.	1 · ·	15	this tape, when you received the file materials,
6	have any ischemia?	16	and I have gone through everything that you have
7 A.	Patients with abrupt occlusion of the right	17	reviewed, did you look at the tape first?
8	coronary artery, which is usually the artery that		No, I did not.
9	is involved in a spontaneous dissection, or in		Did you read the material first and then review
20	this case involved in an iatrogenic dissection,	20	the tapes?
!1	especially somebody who has a large dominant		Yes.
!2	right coronary artery like this, will develop		Did you find an inconsistency between your
:3	significant elevations in the pulmonary arterial	23	interpretation of the September 14 film and the
:4	pressures if they have global ischemia involving the right and left ventricles.	24	operative report of Dr. Nukta of the September 14 procedure?
!5		25	

lilbert v	r. Nukta Multi	-Page	Botham. M.D.
	Page 74		Page <b>76</b>
1 A. No,	, I did not.	1 Q.	Does it appear that that right there, that
2 Q. Let	the record reflect that I am going to go	2	dissection that we are looking at at 1:10:02, has
3 ahe	ead and start this.	3	extended retrograde to the valve at that point?
4 ]	Doctor, would you tell me when you first see	4 A.	You don't know that. And right here at this time
5 a si	ign of aortic dissection, and I will hit the	5	you don't even know that there is a dissection.
6 pau	use button.	6	All you know is that there is an abnormal
7 A. The	ere.	7	collection of contrast that is concerning.
8 Q. Tha	at is at approximately one minute and ten	8	What the next step then becomes is that
9 sec	conds?	9	abnormal collection of contrast, that is
0	MR. MEADOWS: That is where you	10	something I need to be worried and concerned
1 stoj	pped it. It might be	1	about. What exactly is the etiology of this
2 Q. Ab	out a minute eight?	12	collection of dye?
3 A. On	e minute eight, one minute nine.	13 Q.	What is the standard of care, then?
4 Q. Ho	w is it that you define dissection?	14 A.	Depending upon whether or not it is noticed at
5 A. I do	on't know that you can specifically say that	15	the time by the person who is doing that, what I
6 the	re is a dissection. What you can say is there	16	would then do would be want to ascertain exactly
7 is a	an abnormal collection of dye in a concentric	l <b>7</b>	what this is, which may entail an injection into
8 fas	hion that would make me concerned that there	18	the sinus of Valsalva to really see" if there is
9 is a	a false lumen or an area of abnormal blood	19	an abnormality there or something that you are
0 ent	try into the wall of the aorta.	20	concerned about, and then perhaps go from that
1 Q. Wo	ould you agree with me that, more likely than	21	situation to try to ascertain whether or not you
2 not	t, at one minute and eight seconds when you see	22	have involvement in the valve or involvement of
3 the	abnormal accumulation, more likely than not,	23	the ascending aorta.
4 it h	had been there at some point prior to the one	24 Q.	You are saying the purpose of that injection
5 min	nute and eight seconds?	25	would be to make sure there is a dissection, that
	Page 75		Page 77
1 <b>A.</b> I th	hink the first time you see evidence of it is	1	that is just not a
	re. I don't think that there is a way that you	2 A.	I think once you see an abnormal go ahead.
	n specifically state what has happened		In other words, the purpose of the sinus
	ecceding that unless you can actually see the	4	injection you are talking about is to make sure
	ocess, it would just be speculation.	5	this is not a transient accumulation of contrast
-	ell, I am going to ask you, with the benefit of	6	material, rather truly is a dissection?
	ndsight, knowing what you see there, if you	7 A.	
	ck it up before one minute and eight seconds,	8	process is that is going on in the sinus of
	you think, more likely than not, there was a	9	Valsalva that has resulted in this abnormal
	ssection there?	10	accumulation of dye here, because you don't
1 A. I th	nink you have entry of blood into a false	11	really know at this time what that is from or
	ssage at this point in time. As to how much	12	what the extent of that process is.
-	e dissection is involved at this time, you	13 Q.	-
4 cai	n't say because you haven't been able to	14	tears as it appears there, assuming this is an
	tually look at the entire aorta.	15	aortic dissection right here, is she a candidate
	<i>e</i> you able to tell me more likely than not the	16	for surgery?
	tent of this dissection?		You don't know from what you see here because yo
	this time, no.	18	don't know what is going on. I would not operate
9 Q. Wł		19	on this patient with this film to look at. I
	cause you are not visualizing the entire aorta,	20	would need more information.
	r are you visualizing the valve.	21 Q.	
	here is the valve?		I would need to know whether or not this is,
-	e aortic valve should be right down in here,	23	indeed, an aortic dissection, whether or not the
	d the rest of the aorta should be coming up	24	tubular portion of the ascending aorta is
25 her		25	involved, and whether or not there is valvar
			Page 74 - Page 7

iilbe	rt v. Nukta Mi	ulti-Pa	ge <sup>1</sup>	Botham, M.D.
	Page	78		Page 80
1	insufficiency. And at this point in time we		A.	I think if you know that there is an aortic
2	don't have any of that information.	2		dissection, the answer to that question is yes.
3 Q.	Let's assume it is an aortic dissection, but	3 (	Q.	Thank you.
4	there is no valvar involvement.	4	<b>A.</b>	At this time I don't think we knew that, indeed,
5 A.	But the problem is you don't know that from this	5		there was a dissection. We knew there was a
6	picture.	6		problem with the sinus of Valsalva.
7 Q.	I am asking a hypothetical.	7 (	Q.	So it is your opinion here at this point,
8	MR. MEADOWS: For this picture, on	8		1:14:12, you still don't know that is an aortic
9	the record, we are talking about 1:10:02.	9		dissection, correct?
0 Q.	Assuming this is an aortic dissection, but it has	0 4	A.	Correct. You have a concern about this, and you
1	not extended into the valve, nor up the aorta,	1		know that there is something pathologically
2	what, as a CT surgeon, would be your opinion on	2		problematic within the sinus.
3	her surgical candidacy?	3 (	Q.	What is your opinion on whether additional
4 A.	If, indeed, this was a localized dissection to	4		interventional measures should take place at this
5	the right coronary sinus of Valsalva and there	5		point when you have this concern?
6	was a problem with the right coronary artery, I	6 .	A,	In terms of what type of interaction?
7	would recommend that she undergo operative			Trying to lay an additional stent, or continuing
8	correction for that.	8		to try to conduct angioplasty, interventional
9 Q.	And what procedure would have to be performed?	? 9		measures versus diagnostic, like an aortogram.
:0	MR. MEADOWS: Show an objection,	20		MR. MEADOWS: I am going to object
1:1	because you have asked and he has answered this.	21		because you left out sinus injections, and I want
2 A	What would be found at the time of operative	!2		to make sure you make a distinction in your
:3	intervention, more likely than not, if this was a	:3		question.
!4	dissection, it would have propagated and involved	1 24	A.	I think if you are concerned at any point in time
!5	the ascending aorta and the aortic valve.	25		about there being a pathologic problem with the
	Page	79		Page 81
1	If it was just localized, then we would have	1		wall of the aorta separate from what the
2	to tailor an operation based upon what was found			procedure was that you were entering the case to
3	at that time of operative intervention.	3		do, then you need to abandon whatever other
	We are at 1:14. Can you tell me whether, in your			intervention on the right coronary artery is
5	opinion first of all, would you describe for	5		being undertaken, provided that coronary <i>artery</i>
6	me what you see.	6		circulation is stable, and then evaluate the
	You see, again, an abnormal collection of dye in	7		aorta to determine what degree of pathologic
8	the right coronary sinus of Valsalva that is	8		problem you have to deal with.
9	suggestive but not diagnostic for a problem	9		In an effort to expedite this deposition, I am
10	within that sinus.	10		going to ask you to go to the cine. machine for
	Now we are at 1:14:12. Is that accumulation of	11		lack of a better description.
12	contrast material larger, or does it appear	12		That is exactly what it is called.
13	larger than the last contrast injection we just			Would you show me what you and Bill were looking
14	viewed?	14	`	at when I was out in the hallway, please.
15	MR. MEADOWS: Objection.	15		MR. MEADOWS: For the record, he
	No. I think you are visualizing it better. I	16		is going through do you want him to tell you
17	don't think the process has changed. I think you	17		what we looked at?
18	have been able to fill the area of abnormality	18	Q.	Why don't we do that from the beginning. Tell me
19	better and to visualize it better. But I don't	19	-	what you see in each injection.
20	think the size of it has changed.	20		MR. MEADOWS: I mean, that is a
21 Q.	May we agree that once you see something on the	21		different question. We didn't necessarily do
22	film which leads you to believe, more likely than			that in the five minutes we were here.
23	not, there is objective proof of an aortic		A.	We are reviewing a catheterization dated 9/14/95,
24	dissection, there is a corresponding duty to	24		presumptively of Janice Gilbert, although her
25	place that into the field of vision?	25		name I don't see on here.
L		<u> </u>		Page <b>78 -</b> Page 81

Gilbe	rt v. Nukta Multi	-Page	TM Botham. M.D.
	Page 82		Page <b>84</b>
1 Q.	If I may just intervene, you are right, Bill.	1	coronaryartery.
2	Doctor when you get to the point when I	2 Q.	And what were those sheath marks? See these
3	asked the initial question, would you show me	3	marks up here?
4	what you and Bill were looking at?	4 A.	I suspect that is the markings on the balloon
5 A.	Absolutely. We are reviewing the left main	5	catheter that is doing the angioplasty.
6	coronary injection performed by Dr. Nukta	6 Q.	This is the sixth view?
7	originally to ascertain whether or not the site	7 A.	The sixth view, and appears to show a dissection
8	of the prior angioplasty and the circumflex had a	8	involving the proximal portion of the right
9	problem in it. And it appears to be satisfactory.	9	coronary artery.
0	The second view, called the right anterior	10 Q.	Is that post-stent, number one?
1	oblique view, to look at that same area. And	11 A.	No, this, I believe, is subsequent to the balloon
2	that, again, looks quite satisfactory.	12	dilatation.
3	An injection is then made in the right	13 Q.	So there is no stent in there?
4	coronary artery.	14 A.	I don't see a stent being placed.
5 Q.	And this is the third view, correct?	15 Q.	Good enough. This is the seventh view coming up?
6 A.	This is the third view, and a left anterior	16 A.	Yes. This may be a subsequent balloon dilatation
7	oblique fashion, and it shows a 60 percent, maybe	17	of the same area. Again, without being there and
8	70 percent, stenosis in the proximal third of the	18	knowing exactly what he is doing", I don't know
9	right main coronary artery.	19	specifically what portion of the procedure he is
0 Q.	Do you have an opinion as to whether that should	20	carrying out at this time.
1	have been angioplastied on September 12?	21 Q.	I amjust concerned that we are losing track of
2	MR. MEADOWS: On the 12th. He is	22	the count here.
3	asking about the first procedure.	23 A.	Do you want to go back and start again?
4 A.	No, I would not have angioplastied this on the	24 Q.	Because I saw a sheath mark before, and I didn't
5	12th. I think the patient developed clinical	15	see the balloon.
	Page 83		Page 85
1	symptoms in the face of prior inferior	1	MR. MEADOWS: You don't have to go
2	infarction. I think it behooves the cardiologist	2	all the way back.
3	involved to make sure this lesion has not become	3 A.	This is the first view, second view, third View,
4	more unstable.	4	which is the first injection of the right
5	At the time Dr. Nukta felt this lesion could	5	coronary artery.
6	present problems for Mrs. Gilbert and felt an	6	Fourth view, which is the second injection
7	angioplasty was indicated.	7	of the right coronary artery. Fifth view, which
8 Q.	Do you have an opinion whether this RCA lesion	8	appears to be the initial percutaneous
9	was the culprit on September 14 that led to her	9	transluminal coronary angioplasty of the right
0	coming down for the angioplasty?	10	coronary artery.
1 A.	I suspect it was the circumflex lesion, and that	11	Sixth view, which then shows an apparent
2	this was present and may not have cultured, but I	12	dissection in the right coronary artery. And the
3	think the actual culprit lesion was the	13	seventh view, which appears to be a subsequent
4	circumflex.	14	attempt to dilate the right coronary artery, as
5	MR. MEADOWS: Asking on the 14th?	15	well, but I can't tell you whether Dr. Nukta had
6	MR. LOUCAS: The 14th before the	16	a stent in there that he was dilatating or was
7	discharge.	17	just doing a subsequent dilatation in an effort
8 A.	I am sorry, I have thought you meant on the	18	to attack back to the dissection.
9	12th. I don't think there is any way to know	-	Eighth?
20	whether or not that is causing the chest pain	20 A.	This is the eighth injection, which continues to
21	that she is experiencing.	21	show a dissection involving the right coronary
22 Q.		22	artery.
23 A.	This is the fourth view.	23	The ninth view again continues to confirm
24	The fifth view appears to be a percutaneous	24	the dissection involving the proximal third of
25	transluminal coronary angioplasty of the right	25	the right coronary artery.
			Page 82 - Page 85

Filber	rt v. Nukta Multi	-Page	<b>Botham. M.D.</b>
	Page <b>86</b>		Page 88
1 Q.	I am sorry?	1	the proximal portion of the right coronary
2 <b>A</b> .	This is the ninth injection, which continues to	2	artery.
3	show a dissection involving the proximal third of	3 Q.	We are still on number 12, right?
4	the right coronary artery.	4 <b>A</b> .	Yes. Continues to show a dissection involving
5 Q.	But you don't see stents or	5	the right proximal third of the right coronary
6 <b>A.</b>	I don't see a stent being put in here as yet.	6	artery.
7 Q.	Do you know at this point whether the first stent	7 Q.	Any idea whether the stent was laid down there?
8	has been placed?	8 <b>A</b> .	No, I think this is the stent going in here.
9 <b>A.</b>	I do not.	9 Q.	Now we are on number 13?
0 Q.	Okay, please continue.	0 <b>A.</b>	Yes. This, I believe, is where they put the
1 A.	Tenth, a similar right coronary injection which	1	stent. They are inflating the stent here.
2	continues to show the section involving the right	2 Q.	I am sorry. Stop. Is this still 13 or 14?
3	coronary artery.	3 A.	No, this is a new injection. This is number 14.
4 Q.	Can you stop it there?	4 Q.	What is that now?
5 <b>A.</b>	Yes.	5 A.	This is what appears to be an abnormal collection
6 Q.	That catheter, the tip of the catheter, where	6	of contrast material.
7	would you describe that?	7 Q.	Is it fair to state this is the first time you
8 <b>A.</b>	It is in the proximal portion of the right	8	have seen it, then?
9	coronary artery.	9 <b>A</b> .	This is the first time when you have seen the
20 Q.	So it is not in the ostium, or would that be the	20	abnormal collection of contrast material.
21	wrong definition?	!1 Q.	And that is the 14th shot, correct?
22 <b>A.</b>	I think all you can say is that it is in the	22 <b>A</b> .	Correct.
23	region of the ostium of the right coronary		What else do you see in there, please, Doctor?
24	artery, but appears to actually be engaged into	24 <b>A.</b>	You continue to see dissection involving the
25	the proximal portion itself.	25	proximal third of the right coronary artery, and
	Page 87		Page 89
1 Q.	So what is your definition, then, of a sinus	1	you continue to see reasonably good antegrade
2	injection?	2	flow down that artery.
3 A.	A sinus injection is where the catheter itself is	3 Q.	And the stent is the first stent that has been
4	outside of the orifice or the ostium of the	4	placed, correct? You can't visualize it, but we
5	coronary areas in which the sinus is being	5	assume so.
6	injected.	6 A.	We assume it has been placed, and I think in this
	What do you see in this tenth shot?	7	situation I think the second stent had actually
8 <b>A.</b>	I see a guiding catheter in the proximal portion	8	already been placed. I think this one was the
9	of the right coronary artery, and a wire down the	9	second stent going in.
10	right coronary artery itself, and a dissection	10 Q.	Where is the first one, then, if that is the
11	involving the proximal third.	11	second one?
_	Still one dissection?	12 <b>A</b> .	Again, they are difficult to visualize on here.
	Involving the coronary artery itself.	13	I can't tell you specifically where exactly the
	Please go ahead. This is 11.	14	stent is that is being put in, but I think at
15 <b>A.</b>	Here the guiding catheter appears to have come	15	this point in time the second stent has already
16	out of the ostium of the right coronary artery,	16	been implanted.
17	And the right coronary artery is very poorly	_	Is this the first balloon that we have seen?
18	filled, really of no clinical benefit.		No. If you recall back here I will go back
19	Guiding catheter, this is now 12th	19	and show you here.
20	injection, this is now back in the right coronary		Now we are going to lose
21	ostium.		No, we will go back. We know where we are.
22 Q.		22	This appears to be, and I don't know whether
23	here?	23	this is the first stent or actually the second
24 A.		24	stent, you would need to talk with Dr. Nukta at
25	right ventricle or right atrial branch coining off	25	what point in time in this catheterization film

Jilbe	rt v. Nukta Multi	-Page	<b>Botham. M.D.</b>
	Page <b>C</b>		Page 92
1	he is actually deploying the stents.	1	before, and I will just follow along.
2 Q.	Is this just where we were?	2 A.	The first injection is the diagnostic.
	No, this is not where we were.	3 Q.	
4	MR. MEADOWS: I mean, I have lost	-	Yes. Two injections of the left coronary artery
5	track of where you are at.	5	are made.
6 A.	This is 12 here, guys, this is 13.	6 0.	Beginning at 21 seconds.
7 Q.	That is why I wanted to use the		Right coronary artery is then examined at 28
8 A.	This is the second injection here. We are	8	seconds on two separate views up until 37
9	comfortable with that?	9	seconds.
0 Q.	Yes.	10	Then an angioplasty is begun on the proximal
1 A.	Third injection, that is a diagnostic of the	11	right coronary artery at 38 seconds.
2	right. Fourth injection. Fifth injection is the	12 Q.	Okay, Doctor, I am going to interrupt and ask you
3	dilatation and/or stent. I don't know if he put	13	at 38 seconds to back up just to before 36
4	a stent in here or not at this time.	14	seconds and hit the pause, and I want you to
5 Q.	And you see dilatation, but you don't see	15	define for me something that I see on here. Does
6	okay, dilatation.	l6	it have single advance?
7 A.	Now, this is probably where he put the first	l7 Α.	No, it doesn't. That is the problem With this.
8	stent in right here. That is the diagnostic,	18	It is not my VCR, unfortunately.
9	that is the fourth shot. Fifth shot is the	19 Q.	Ĩ
0	initial angioplasty. Sixth shot shows the	20	tion. So if you want to 38:02, are you able
1	dissection.	21	to tell me what that is at the end of that
2	MR. MEADOWS: Be clear in terms	22	catheter, that accumulation that I am looking at
3	of	23	right there?
4 A.	Sixth shot shows the dissection in the proximal		No.
5	portion of the right coronary artery. The	25 Q.	Could that be the beginnings of accumulation of
	Page 91		Page 93
1	seventh shot appears to be placement of the first	1	contrast material?
2	intracoronary stent in the right coronary artery	2	MR. MEADOWS: Objection.
3	in an effort to take care of the dissection		Contrast material where?
4	involving the right coronary artery. The seventh	-	Right here.
5	shot is, again, of the right coronary artery.		Well, there is contrast material there. There
6 Q.	I am sorry, the last one you just said was the seventh.	6	appears to be contrast material there.
7	MR. MEADOWS. Just for the record,	-	. I am <i>sorry</i> , could that be consistent With accumulation due to an aortic dissection?
8	I have totally lost track.	8	MR. MEADOWS: Objection.
0 Q.	Gentlemen, I hate to do this, I know this machine	-	There is nothing there that suggests that is the
$\begin{vmatrix} 0 & Q_{1} \\ 1 \end{vmatrix}$	is better, but why don't we do it through the	10 A	case.
2	film. If we want to expound, we can do it		And before we get to each one, if you want, the
13	correspondingly on here.	12 Q	best thing would probably be to hit pause and
13	MR. MEADOWS: For the record, I	13	then say what frame. What shot we are looking
15	totally lost track of the injections throughout	15	at?
16	the entire time we were looking through the cine.		This is at 42 seconds.
17	film.		This would be I will go ahead and represent
18	In fairness to the doctor, we literally got	18	this the sixth shot. Go ahead.
9	the cine. film five minutes before we started.	19 A	
20	(Thereupon, a discussion was had off the	20	sometimes it pauses and sometimes it doesn't. It
21	record.)	21	is just not a good VCR.
22 A	This film is actually better than the cineangio-	22	This appears to be at 44 seconds, the first
23	gram, it is more clear.	23	stent deployment, which would be number seven.
24 Q.	Here is your "play" and "pause." Just go ahead	24	The next shot is at 47, and that would
25	and narrate it quickly up to where we were	25	appear to be a diagnostic study that shows
			Page 90 - Page 93

Gilbe	rt v. Nukta Multi	-Pag	$ge^{TM}$ Botham, M.D.
	Page 94		Page 96
1	persistent dissection involving the right	1	visualized. The size of it is irrelevant. You
2	coronary artery.	2	don't know whether it has changed in size. It
3	MR. MEADOWS: You went back too	3	certainly is better visualized here than before.
4	far.	4 Q	2. Is that accumulating between the layers of the
5	THE WITNESS: You can't control	5	aorta?
6	this thing.	6 A	A. You can't be certain. But that would be my
7 Q.	Does that look like a dissection to you?	7	concern, that this dye collection has developed
8 A.	No. This is 50, which should be number eight.	8	between the adventitia of the aorta and the media
9 Q.	I have number nine. What do you see in there?	9	of the aorta.
0 A.	50 is number nine. You missed it, I was right,	0 Q	2. And if you were injecting your guiding catheter
1	it is number eight. Number eight is a diagnostic	1	right there into that space that you just
2	study. Go back to number eight. It is a	2	described, what would you expect?
3	diagnostic study of the right coronary artery.	3 A	A. Well, nothing. The majority of the dye is going
4	That is at 48.	4	down the right coronary artery. As you say,
5	Now this is number nine, and that is another	5	there is no real excess pressure involved in the
6	diagnostic study that shows persistent	6	sinus injection itself or the right coronary
7	dissection.	7	injection. Most of the dye is running off to the
8	Number ten is this one at 54, which	8	right coronary artery.
9	continues to show the dissection involves the	9	What you do see is an abnormal collection of
0	right coronary artery. This is, then, the 10th	!0	dye that appears to be in the wall of the aorta
1	injection.	!1	itself.
-	That would be	!2 Q	Q. What is your definition, or how would you define
3 A.	The 11th injection, which continues to show the	23	an intimal flap?
4	right coronary artery dissection. I missed one.		A. An intimal flap is any laceration or disruption
5 Q.	See if you can stop it at about 1:04.	25	of the intima itself that allows for separation
	Page 95		Page 97
1	MR. MEADOWS: We are at 1:04:13.	1	of the wall, the intima perhaps from the media or
2 A.	This appears to be an injection in the right	2	the intima and the media from the adventitia.
3	coronary artery.	3 Q	Q. More likely than not, is that what we have here
	That is the first sign of accumulation of	4	at 1:15:22?
5	contrast material, correct?		A. What it appears to be is you have here a
	No. This is a diagnostic study of the right	6	collection of dye that is accumulating in the
7	coronary artery which continues to show	7	wall of the aorta. Exactly where the wall is,
8	dissection involving the right coronary artery.	8	you don't know, but you know that it is
9	There is nothing to suggest any abnormal aortic	9	accumulating in the wall of the aorta rather than
0	pathology at this point.	10	intraluminally.
	Now, 1:08:25, this is the first time when		Q. So, more likely than not, that is consistent with
2	you see contrast in the sinus that has not	12	an intimal flap?
3	dissipated. This injection shows something	-	A Correct.
4	abnormal within the sinus of Valsalva, the	1	Q. All right. Please proceed.
	etiology of which you can't be certain.	1	A. The next injection is at 1:17:23.
6 7	The next injection is at 1:13:16, which is an injection of the right coronary artery, in the	1	<ul><li>Q. Go ahead and tell me what you see.</li><li>A. That shows an aortic dissection with aortic</li></ul>
8	sinus of Valsalva.	17 A	insufficiency and involvement of the tubular
	What does it show, a widening?	18	portion of the ascending aorta.
	It shows an abnormal collection of dye in the		Q. And that is what I wanted to ask you what is that
10 A.	right coronary sinus of Valsalva.	20 Q	circular appearing substance that we see there?
	Does the fact that it has widened since the		<b>A.</b> This right here? That is the sinus of Valsalva.
1.2 Q.	previous shot mean it is in the intimal flap?	22 A	This is the true lumen here, and this is the
	No. All it means is that the area that you	23 24	false lumen. And you will see it extends up
!5	visualized before as abnormal is now being better	25	through the tubular portion of the ascending
L			Page 94 - Page 97

Giilbe	ert v. Nukta M	lulti-Page	Botham, M.D.
	Page	e 98	Page 100
1	aorta. And you will also see evidence of aortic	1	the wall, within the true lumen of the aorta and
2	insufficiency, the degree of which you aren't	2	this is the false lumen of the aorta.
3	able to ascertain at this time.	3 Q.	The contrast material in this view only appears
4 Q.	Would this be the circumferential 90 to 280	4	to proceed up about one-third to, say, 50 percent
5	degrees you were talking about?	5	of the height of the aorta?
6 A.		6 A.	That is because the overwhelming percentage of
7	two-dimensional picture what the three-	7	the contrast material still is within the true
8	dimensional involvement is.	8	lumen of the aorta. If the catheter were placed
9 0.	Could this be consistent with the contrast	9	in the false lumen and then injected, you would
10	material admixed with the blood filling space of	10	visualize the entire false lumen.
11	an intimal flap, and that is the marking that we	11 Q.	
12	see?	12	attention of Bill in the cine. films?
13	MR. MEADOWS: Objection.	13	MR. MEADOWS: Objection. It
	What you are seeing here is the sinus of Valsalva	1	assumes that he did.
15	being filled with contrast, and a dissection	15 A	
16	within the sinus of Valsalva extending into the	16	saw that was different than this. In fact, we
17	tubular portion of the ascending aorta.	17	were concerned that the character of the cine.
	Can you see whether it is extending into the	18	films wasn't going to be as good as this, and,
19	valve at this point?	19	indeed, that is the case.
1	Yes, there is evidence of valvar insufficiency.	20	MR. LOUCAS: Did I forget to ask
1	Do you see evidence of dissection into the	21	him anything?
22	valve? I mean, do you see visual evidence,	22	MR, MEADOWS: I can't tell you.
23	objective evidence?	23	MR. LOUCAS: Off the record.
	The dissection doesn't extend into the valve.	24	(Thereupon, a discussion was had off the
25	What it does is remove the supportive structure	25	record.)
	Pag		Page 101
1	of the valve, which is that in the sinus of	1	MR. LOUCAS: I don't have any more
2	Valsalva, that results in the leakage in the	2	questions.
3	valve.	3	
4 Q.		4	(DEPOSITION CONCLUDED.)
5	findings did involve the valve, correct?	5	
	No, it did not, it involved the supportive	6	
7	structure of the valves. The valves themselves	7	
8	don't get dissected because they are fibrous, the	8	MARK JUDSON BOTHAM, M.D.
9	supportive structure of the valves does.	9	
10	The next injection is at 1:22:13, and it	10	
11	appears to be a sinus injection that confirms the	11	
12	dissection. And you can see the false lumen here		
13	extending upwards, and this is the true lumen	.13	
14	here.	.14	
15	The next injection is at 1:28:01, and that	15	
16	is an aortogram that delineates the full extent	16	
17	of the dissection and the degree of aortic	17	
18	insufficiency.	18	
	But you cannot see the extent of dissection up	19	
20	the aorta?	20	
	Yes, you can.	21	
22 Q.	•	22	
-	Yes. This is the true human here, and the false	23	
24	human is out here. This is the aorta as it comes	23	
25	up here. This is where the catheter is within	25	
L			Page 98 - Page 101

## Gilbert v. Nukta

ilbert v. Nukta	Multi-Page	Botnam, M.D.
CERTIFICATE	Page 102	
State of Ohio, ) ) S S		
County of Cuyahoga.)		
I, Diane M. Stevenson, a Registered Professional Reporter and Notary Public in and		
for the <b>State</b> of <b>Ohio</b> , duly commissioned and qualified, do hereby certify that the		
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 by him was by me reduced to <b>stenoty</b> py in the		
I, Diane M. Stevenson, a Registered Professional Reporter and Notary Public in and for the <b>Szte</b> of <b>Chio</b> , duly commissioned and qualified, do hereby certify that the within - wed witness, <b>MARK JUDSONBOTHAM</b> , <b>M.D.</b> . 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 by him was by me reduced to <b>Stenotypy</b> in the presence of said <b>witness</b> , <b>afterwards</b> transcribed by means of computer-aided transcription, and that the foregoing is a true and correct transcript of the testimony as given by <b>him</b> as aforesaid.		
transcript of the testimony as given by him as aforesaid.		
I do further certify that <b>this</b> deposition was <b>taken</b> at the time and place in the foregoing caption specified, and was completed without		
caption specified, and was completed without adjournment.		
I do further certify that I <b>am</b> not <b>a</b> relative, employee or attorney of any <b>party</b> , or otherwise interested in the event of <b>this</b> action.		
otherwise interested in the event of this action.		
INWITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this day of 1998.		, and
1998.		
D'i m M. Stevenson,RMR Notary Public in and for The State of <b>Chio.</b>		
My Commission expires October 31, 2000.		
*		