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Ms. Ingrid Kinkopf-Zajac
1375 E. Ninth Street
One Cleveland Center 9th Floor
Cleveland, OH 44114

RE: Michael Paolella vs Erica Remer, M.D. et al

Dear Ms. Kinkoph-Zajac:

Thank you for allowing me to review the medical records of Beverly Paolella. I have been asked to submit a report regarding the standard of care provided by Dr. Sonia Kirk and Lake Emergency Services, Inc.

Mrs. Paolella was a 59 year old female who presented to the Emergency Department at Lake West Hospital in Willoughby, Ohio on the morning of 8/22/02 with shortness of breath over the last two to three days associated with URI symptoms of nasal congestion, cough and productive sputum. The patient was assessed and treated over 3 ½ hours in the Emergency Department where she received multiple aerosol treatments, clinically improved and subsequently discharged with the diagnosis of pneumonia. The patient underwent laboratory studies and a chest x-ray where radiologist's interpretation was CHF with edema and/or unusual pneumonia. Laboratory studies were unremarkable for any significant abnormalities other than an elevated glucose at 348. The patient's vital signs remained stable the entire time in the Emergency Department with normal blood pressure, pulse rate, normal oxygen saturation ranging from 94 to 97% and minimal tachypnea ranging from 20 to 24 that clearly could be consistent with mild CHF or pneumonia. She was given a dose of IV Levaquin and discharged on an Albuterol metered dose inhaler.

Based on her presenting symptoms and her clinical course in the Emergency Department along with the x-ray findings provided, clinical correlation would be consistent with the diagnosis of atypical pneumonia/bronchitis making this course of management appropriate based on her Emergency Department presentation. X-ray findings of atypical pneumonia may present with interstitial fluid/infiltrate and can be indistinguishable from CHF, therefore, warranting clinical correlation to make the most appropriate management decisions. Based on her presentation, her symptoms clearly appeared to be of an infectious etiology and with no prior history of CHF in this patient, the management decisions made in this case, I feel, were reasonable and appropriate in this scenario.

Unfortunately over the ensuing several hours, the patient became more ill with nausea and vomiting and presented back to the Emergency Department for admission at 15:40 (approximately 5 hours after her earlier Emergency Department discharge). At this visit John Novac, PA, along with Dr. Kirk, saw the patient and admission to the hospital was promptly arranged through Dr. Kotak. Once again on presentation back to the Emergency Department, vital signs were stable, blood pressure 119/67, pulse rate 88, respiratory rate 20 and patient was afebrile. She was given IV Phenergan an antiemetic for her nausea and an IV was established and treated with an Albuterol acrosol. Dr. Kotak also evaluated the patient at 17:06 in the Emergency Department and she was subsequently transported to the flood for her admission at 18:20 where her vital signs remained stable at that time. The patient was placed on IV antibiotics and given an antiemetic for continued nausea and vomiting. At approximately midnight (5 ½ hours after her admission) the patient became light-headed while going the bathroom and developed a syncopal episode. She regained consciousness and a house officer was notified to evaluate the patient where a cardiac workup was initiated. She was sent to the Emergency Department due to her unstable vital signs of hypotension (BP 90/60), tachycardia (from 100 to 130) and tachypnea (22-40). She was started on Dopamine to support her blood pressure and suffered a cardiorespiratory arrest at 02:25 on 8/23/02. The patient subsequently expired. Autopsy revealed severe arthrosclerotic cardiovascular disease with both acute and remote myocardial infarcts and pulmonary congestion.

It is my opinion that the patient expired from an acute myocardial infarction that had already progressed beyond the point of a reasonable probability of recovery by the time she presented to the Emergency Department even on her initial visit on 8/22/02. Her presenting symptoms on this occasion though, were extremely atypical for this ultimate diagnosis and subsequent death, and in fact I would not anticipate any reasonable Emergency physician to have made a determination, diagnosis and subsequent treatment plan for acute myocardial infarction based on her initial presenting complaints.

My opinion is based on the review of the medical records provided to me and I can not rule out altering this opinion if there is additional and/or different information provided to me that would contradict the data provided in the medical records.

Sincerely,

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Medical Director, Emergency Department
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KRB/jc