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IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

Case No. 497453

JANET WOYMA, etc.

Plaintiff

vs.

THE CLEVELAND CLINIC FOUNDATION

Defendant

DEPOSITION OF RICHARD PAUL CAMBRIA, M.D.

Wednesday, October 29, 2003

Massachusetts General Hospital

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October 29, 2003 5:33 p.m.

PROCEEDINGS

RICHARD PAUL CAMBRIA, M.D., Sworn

EXAMINATION

BY MS. EKLUND:

Q. Doctor, would you state your full name for the record, please.

A. Richard Paul Cambria.

Q. And you are with Massachusetts General Hospital?

A. Yes, ma'am.

Q. Do you have a private practice in addition, or is it just hospital-based?

A. My practice is entirely hospital-based at this hospital.

Q. And you are presently chief of vascular surgery at Massachusetts General?

A. Chief of vascular and endovascular surgery at Mass. General.

Q. When did you take on the title of endovascular chief?

A. The division name was changed approximately a year ago.

Q. When did they start doing endovascular

surgeries at Massachusetts General?

A. It depends on what you mean by "endovascular surgeries."

Q. All right. Endovascular surgery for abdominal dissections.

A. Well, abdominal dissections are extremely rare, so that no one "does" routinely endovascular surgery. But if it suffices as a surrogate, we have the longest and largest experience with endovascular repair of aortic aneurysms in New England, and the first endovascular repair of an aortic aneurysm was done at this hospital in 1994.

Q. Was it done by you?

A. No, it was not.

Q. And you say you have the largest center here for endovascular repair of aortic aneurysms?

A. Aneurysms in New England.

Q. When you say aneurysms, does that also include dissections?

A. It does not.

Q. There is a difference between the two; correct?

A. Yes, there is.

Q. What about in terms of endovascular repair

of dissections for the abdominal aorta?

A. Endovascular repair of dissections are done when indicated. We do both open and endovascular repairs of aortic dissections.

Q. And how long have you been doing endovascular repairs of aortic abdominal dissections?

A. Dissections? Well, we had about 15 cases during the 1990s, so over a decade.

Q. How many do you presently do on an annual basis of endovascular repair of aortic abdominal dissections?

A. Well, on an annual basis, I probably do five to ten procedures for aortic dissection. Some are endovascular, some are open conventional surgery.

Q. The gist of what I'm hearing from you is that the dissection of the descending aorta is far less common than dissection of the ascending aorta.

A. In the spectrum of aortic dissections, about 60 percent are ascending, 4 percent descending.

Q. And the ascending aortic dissection is more of a surgical management, versus medical management,

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of a descending aortic dissection?
A. That's correct.
Q. And likewise, an ascending aortic dissection is more of an emergency procedure than a descending abdominal dissection, aortic?
A. That's a fair statement.
Q. Can you tell me how you divide up your professional time in terms of your responsibilities as chief of vascular surgery versus patient care and/or teaching?
A. I spend about 90 percent of my time in the direct care of patients, and my teaching is in the context of my practice. My teaching is almost 100 percent done on hospital wards, in the operating room, in the endovascular suite. I don't sit in classrooms and lecture. My teaching outside the hospital is in the context of postgraduate courses, visiting professorships, and so forth. But I spend 80 to 90 percent of my time in the clinical care of patients.
Q. How much of your time do you spend in the role of an expert witness?
A. .05 percent.
Q. How long have you been providing expert

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services in medical-malpractice cases?
A. I don't know the answer to that. I don't know when I did the first one. But it's been over ten years, if that helps.
Q. And can you tell me on an average how many cases per year you review?
A. I probably look at approximately ten cases a year.
Q. Has that number been fairly constant since you started doing expert work?
A. No. I think it's been about ten cases per year over the past five years.
Q. Can you tell me how the cases divide in terms of whether you're reviewing on behalf of a physician or a hospital versus on behalf of a patient?
A. About 90 percent are on behalf of defendants.
Q. When was the last time you reviewed a case at the request of a plaintiff, or patient?
A. A case just finished up; within the past six months the case was settled. The case involved an acute ascending dissection of the aorta.
Q. Was the question a failure to timely

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intervene?
A. Failure to diagnosis.
Q. Have you testified in other cases involving dissection of the descending aorta?
A. What do you mean by "testify"? Given deposition, reviewed a case, or testified in court?
Q. I'll break it down. Have you reviewed cases relative to a dissection of the descending aorta?
A. I am certain that I have, although I can't recall a specific case at the moment.
Q. Have you testified in a case involving a descending aortic dissection?
A. Testified in court?
Q. No, deposition, like we're sitting here now.
A. I can't recall one that I have.
Q. How about trial?
A. No, no. I've only been in court twice.
Q. Where was the case that you just finished, on the ascending aorta, venued?
A. New Haven, Connecticut.
Q. Have you ever testified in a court in Cleveland, Ohio?

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A. No, I have not.
Q. Generally, what types of medical care have you been involved in in terms of your expert review?
A. Most, a preponderance --
Three areas: general vascular surgery -- and that includes anything in the spectrum of vascular surgery -- aortic aneurysms, circulatory problems in the leg. But I tend also to see a lots of complex aortic things because of what I've written and what I am known for, and they include aortic dissection and thoracal-abdominal aortic aneurysms.
Q. In your present practice is there a particular area of vascular surgery where you spend most of your time?
A. What I'm known for regionally and nationally is complex extensive aneurysm disease. So on a proportion and percentage basis, I do more of that, certainly, than the average vascular surgeon. That and endovascular surgery are the things that I do mostly.
Q. What has been your success rate with endovascular repair of descending aortic dissections?

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A. I don't have a sufficient number of those to put a numerator/denominator on it. I would say -- we've written on this. The overall success rate of an intervention for a complicated dissection tends to run in the 70 percent range.
Q. That means a successful intervention, the patient survives?
A. The patient survives.
Q. Do you treat Marfan's patients in your practice?
A. Yes, I do.
Q. I'm assuming Marfan's is a relatively rare disease?
A. It's relatively rare. It's much more uncommon than degenerative aneurysm in an elderly patient, yes.
Q. Can you tell me how many Marfan's patients you've treated, let's say, in this year, 2003? We're in the end of October.
A. I can't remember one this year. Let me think about that for a minute.
I don't know that I've done a Marfan's patient this year. I can't recall offhand. I have certainly operated on patients with Marfan's

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syndrome, but I can't remember a specific one that I did this year, because I don't think I did.
Q. When is the last time you remember doing surgery on a Marfan's patient?
A. A couple years ago.
Q. And can you recall what it was you did?
A. Yeah. It was a thoracal-abdominal aneurysm resection.
Q. And how was it managed surgically?
A. By replacement of the aorta with a thoracal-abdominal aortic graft.
Q. You replaced the entire aorta?
A. The thoracal-abdominal aorta. I have never, and one does not ever, replace the entire aorta at one sitting.
Q. Have you ever been involved in any professional relationship with the Cleveland Clinic?
A. In terms of medical care? What do you mean by a "professional relationship"?
Q. In terms of either your medical specialty, serving on a panel, or consulting.
A. I was at the Cleveland Clinic lecturing at a course that they gave, Summit on Aortic Surgery, first week in September.

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Q. Of this year?
A. Yes.
Q. Who asked you to come out there?
A. Dr. Ken Ouriel, the chairman of vascular surgery out there.
Q. What was the subject of your lecture there?
A. The subject of my lecture was spinal-cord ischemia in the course of thoracal-abdominal aneurysm repair.
Q. Had you lectured at the Cleveland Clinic on prior occasion?
A. I don't believe I had.
Q. Had you ever been to the Cleveland Clinic before?
A. Yes, I had.
Q. For what reason?
A. I've been there as a visiting professor.
Q. What time frame? I don't mean to interrupt, but before you get too far ahead of me.
A. I was there as a visiting professor and professional lecturer two years ago. I was there --
Q. I'm sorry, for how long a time frame were you there?
A. That was for a lecture, a day. I was there

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yesterday for an investigators' meeting for a national trial on which I am on the steering committee.
Q. Why was the meeting held at the Cleveland Clinic?
A. Because the investigator who did the Phase 1 study on this particular device is based at the Cleveland Clinic and all of the experience in the country with this particular device for this particular thing has been done at the Cleveland Clinic.
Q. Who is the investigator at the Cleveland Clinic?
A. Roy Greenberg, M.D.
Q. And he's a vascular surgeon?
A. He is.
Q. And what is the device that you're speaking of?
A. It is a thoracic-aortic stent graft.
Q. And how long have you been working with Dr. Greenberg relative to this device?
A. I was asked to join the national steering committee for this study within the past two months.
Q. And who's sponsoring the study?

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A. Cook, Incorporated.
Q. I assume that's a pharmaceutical or --
A. It's a medical-device company.
Q. How long is the study expected to last?
A. Well, it hasn't started yet. And how long it lasts is dependent on how quickly the enrollment of study subjects goes. And then after the enrollment there is a follow-up period. So the period of follow-up will be years. The period of enrollment will probably be approximately one to two years, once it actually starts.
Q. How many patients do you hope to have in the study?
A. There are 100 test patients and 50 control patients.
Q. How many patients do you have here at Massachusetts General that are part of that study, if any?
A. Well, it hasn't started yet.
Q. Well, you haven't identified any patients yet; is that correct?
A. Right.
Q. Okay. How is this thoracic stent device different from anything else that's been used?

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A. It is a different construct, as opposed to the other two thoracic aortic stent grafts, which are also both just beginning clinical trials.
Q. Have you had any other occasions to be at the Cleveland Clinic?
A. Yes.
Q. And what would that be?
A. I was there doing some postgraduate training in vascular surgery in October of 2001.
Q. And that would have been in vascular surgery?
A. Yes, ma'am.
Q. And who did you train with?
A. Dr. Roy Greenberg, Dr. Dan Clair, Dr. Sean Lydon, Dr. Ken Ouriel, Dr. Sunit Srinivasta -- S-r-i-n-i-v-a-s-t-a. And that's it.
Q. How long were you there for that postgraduate training?
A. Six weeks.
Q. Why did you choose the Cleveland Clinic for that postgraduate training?
A. Because I felt, when I looked at the various opportunities around, that they had the best program.

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Q. Were you invited to attend that program there, or did you just --
A. I applied.
Q. You applied.
A. I applied.
Q. And who was your contact person when you applied?
A. Dr. Ken Ouriel.
Q. Had you had a past relationship with Dr. Ken Ouriel?
A. Well, I've known him professionally for a long time.
Q. What about Dr. Greenberg? Have you known him professionally for a long time?
A. No, not for a long time, because he's much younger than me. I have known him professionally for -- since he came back to this country from Sweden. I guess that's about four or five years.
Q. How about Dr. Clair? Did you know him before you did the postgraduate training?
A. Did not.
Q. How closely did you work with Dr. Clair during your --
Is it six weeks?

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A. Yes.
Q. -- six-week postgraduate training period?
A. I worked with all of those physicians that I named closely.
Q. Have you had contact with Dr. Clair since your postgraduate training at the Cleveland Clinic?
A. I have seen him at meetings, yes. I saw him in a meeting two weeks ago.
Q. He's here at Columbia?
A. In New York, at Cornell, Columbia.
Q. You're right. I've forgotten where I am.
A. This is Boston.
Q. This is Boston. You are right.
Is that a regional sort of conference that you saw him at two weeks ago?
A. It was a national meeting.
Q. Did you speak to him there?
A. I spoke to him at the hotel desk checking in.
Q. Is he aware of your involvement as an expert witness in this case?
A. I don't know. I don't know.
Q. Have you ever discussed it with him?
A. I have not.

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Q. Have you discussed this case with any of the other doctors at the Cleveland Clinic?
A. I have not.
Q. Who asked you to become involved as an expert witness in this case?
A. Mr. Jackson.
Q. And how is it that Mr. Jackson came to contact you?
A. I don't know the answer to that.
Q. Had you ever worked with Mr. Jackson before?
A. No.
Q. Had you ever worked with any Cleveland law firms before?
A. The answer to that must be yes, because I reviewed a case from the Cleveland Clinic about two or three years ago. But I don't know the law firm.
Q. What was the nature of that case?
A. It was a case of spinal-cord ischemia and thoracal-abdominal aneurysm repair.
Q. And you were reviewing it on behalf of the Cleveland Clinic?
A. Yes -- on behalf of the surgeon.
Q. Do you recall who the surgeon was?

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A. I think his name was Semba, S-e-m-b-a, or S-e-m-b-r-a -- not someone that I had previously known or I had any professional knowledge since.
Q. I take it he was a vascular surgeon at the clinic?
A. He was not.
MR. JACKSON: Dr. Cambria, did you in that case generate a report?
THE WITNESS: I don't remember.
MR. JACKSON: And did you testify by deposition or otherwise in that case?
THE WITNESS: I don't believe that I ever did.
MR. JACKSON: As far as you know, all you did was consult in that?
THE WITNESS: Well, I reviewed a record and gave an opinion.
MR. JACKSON: Then if you were just consulted on that, didn't generate a report, weren't identified, then I don't think that's a proper area of inquiry. You may have been just, from the sounds of it, a consulting expert. So I think the extent of her inquiry should end right there.
MS. EKLUND: Well, I disagree.

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MR. JACKSON: Who knows whether there was a case. Who knows what happened with the case. Who knows if he was identified as an expert. If he wasn't identified as an expert, I don't think you're entitled to explore that.
MS. EKLUND: I think I am. I'm not asking any of the strategies or thought processes of counsel. I'm not intending to delve into that.
Q. I simply want to know: Did you find deviation from the standard of care?
MR. JACKSON: Doctor, I would instruct you -- although you're not my client, I don't think that's a proper question for to you answer at this time. If the Court disagrees with that and you have to answer at a later time, we can deal with it then. But under the circumstances, I don't think that's a proper question for you to respond to.
Q. For the record, you are not Mr. Jackson's client, are you?
MR. JACKSON: He's not. There's no question. I'll stipulate that. So I'm not advising him -- I can't tell him not to answer the question. I think it's an inappropriate question.
MS. EKLUND: But you did advise him not

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to answer.
MR. JACKSON: I did say I don't think he should answer that question. If we have to take that up with the Court, we will.
Q. Doctor, will you answer the question?
A. I'll answer the question.
Q. All right. Please do, then.
A. What's the question?
Q. The question is, did you find in reviewing that case that there was a deviation from the standard of care by any of the physicians from the Cleveland Clinic?
MR. JACKSON: Again, I'll object.
A. I found no deviation from standard of care.
Q. Can you recall any other occasion where you reviewed medical records on behalf of or at the request of the Cleveland Clinic or any of its physicians?
A. I can't.
Q. Do you have any familiarity with a law firm known as Jacobs and Maynard, Tuschman, and somebody else -- I can't remember it now?
A. And where are they?
Q. They were in Cleveland. They're now

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defunct.
A. I don't know.
Q. It would ring a bell? If it does, it does.
A. Well, it might, but it might not. I might remember cases, but believe me, I don't remember the law firms that represent the clients.
Q. To your knowledge, have you ever worked for Mr. Jackson's law firm before, Roetzel & Andress?
A. Not to my knowledge.
Q. Have you ever been a patient yourself at the Cleveland Clinic?
A. I have not.
Q. Any family members?
A. No, ma'am.
Q. Have I covered all of the, I guess, affiliations or time that you've spent at the Cleveland Clinic prior to today? It was the postgraduate training you had in 2001. Is that the end of it, or was there something before that?
A. Not before that, no.
Q. And since then, other than being in an investigative study with Dr. Greenberg and the visiting lecturer there yesterday, is there anything more?

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A. Investigators' meeting yesterday. I was a visiting lecturer there the first week in September, was that course.
Q. Is that the extent of your involvement with the Cleveland Clinic?
A. Yes, ma'am.
Q. To your knowledge, do you serve on any medical boards or medical-journal editorial boards with any of the doctors from the Cleveland Clinic?
A. I don't know. I'm on lots of editorial boards. Whether or not someone from the Cleveland Clinic is on the same editorial board, I just can't recall. But if you wait one second, the --
Q. Here's your CV. Would that help you?
A. No, because that's not going to say who the other members of the editorial board are. Isn't that your question?
Q. Well, I don't want you to go through journals. As we sit here today, nobody comes to mind. That would satisfy me.
A. Well, there's one that I should check, because the Journal of Vascular Surgery, which is a prominent journal, I am on the editorial board and have been for years. And I think that Ouriel was

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just --
Ken Ouriel, from the Cleveland Clinic, is also on the editorial board of the Journal of Vascular Surgery.
Q. Thank you. How long have you been on the editorial board of the Journal of Vascular Surgery?
A. This is my second third-year term, so approximately four years.
Q. Do you find that to be an authoritative, reliable text in your field?
A. The Journal of Vascular Surgery is the single most prestigious, most widely read journal in the field of vascular surgery.
Q. So you do find it reliable and credible?
A. Well, there are lots of articles published in this journal every month. Do I agree with everything that is said in every one of them? Absolutely not.
Q. I notice, Doctor, on your CV that you have a chapter in preparation on Aortic Dissection Perspectives.
A. Perspectives for the Vascular and Endovascular Surgeon, Rutherford Textbook of Vascular Surgery.

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Q. Yes. Is there a draft of that chapter that would be available for my review?
A. No.
Q. Have you started it?
A. Oh, it's almost finished, but I don't have a draft available for you.
Q. Are you not allowed to release it prior to publication?
A. Well, I wouldn't, and it's quite frankly between me and my coauthor still going back and forth.
Q. Do you know when that's expected to be published?
A. I don't know the publication date for the next edition of the Rutherford Textbook of Vascular Surgery, since the chapter is now three weeks overdue, and I think publication on the next edition is due kind of mid- to fall 2004. It will be a very comprehensive chapter on aortic dissection, I might add.
Q. I can hardly wait.
A. You will have to buy both volumes.
MR. JACKSON: See if you can get her to commit to that on the record, Doctor.

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(Discussion off the record.)
Q. One name you didn't mention before was Dr. Sarac, S-a-r-a-c, at the Cleveland Clinic. Have you worked with him?
A. I have not worked with him.
Q. You have worked around him?
A. No. I have not worked with him. He was on a leave of absence from the Cleveland Clinic when I was physically there in 2001, so I had not worked with him.
Q. Have you met him since?
A. Yes, I know I have met him, yes.
Q. And what was the setting in which you met him?
A. Vascular-surgery national-meeting sort of thing.
Q. Do you have a professional relationship with Dr. Sarac?
A. No, no more than I have a professional relationship with hundreds of other vascular surgeons in academic vascular surgery.
Q. In terms of your own practice, if you want to consult with or discuss patient treatments or ideas with colleagues outside of your own

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institution, where do you turn?
A. I can't think of an occasion where I've ever done that.
Q. All right, now the part that's important. Tell me what you charge for your services as an expert witness.
A. I charge $3,000 to review a case.
Q. Does that include writing a report?
A. No, it doesn't. I usually charge extra to prepare a medical-expert report.
Q. What do you charge for a report?
A. $500.
Q. What do you charge for deposition time?
A. As we stated, $500 an hour, to be guaranteed $1,000.
Q. Minimum.
A. Right.
Q. And that's for two hours?
A. Right.
Q. And thereafter it's $500 per hour.
A. Yes, ma'am.
Q. And I on my part said I would commit on the record to be paying you for your time here tonight.
A. Thank you very much.

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Q. What about in terms of trial testimony, how do you charge?
A. You know, it so seldom comes up that I don't have a fee schedule or anything like that. But if I'm going someplace to appear in court, I would charge $5,000 plus expenses.
Q. Expenses include travel --
A. Airfare, hotel, whatever it takes.
Q. Do you require to fly first class?
A. I've never made that request of anyone.
Q. It's a good idea.
A. Thank you.
Q. Has Mr. Jackson asked you to take some time away in the week of November the 17th to testify in Cleveland in this case?
A. I believe he has made such a request.
Q. And have you set aside time in your schedule to do this?
A. I believe I have.
MR. JACKSON: Just so we're clear, it's not for that week; it's for Monday, which would be the 24th. You and I had that discussion, but that's the day he is set to come in. You asked him specifically the week of the 17th.

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MS. EKLUND: I did.
MR. JACKSON: He's scheduled for the 24th.
Q. Doctor, have you ever done any research on Marfan's disease or patients?
A. I have written papers that have included patients with Marfan's syndrome. But to answer your question honestly, I've never done any specific research on Marfan's patients.
Q. And likewise, no articles on Marfan's patients?
A. I have written many articles that include patients with Marfan's syndrome.
Q. And is that because Marfan's patients tend to have dissections of the aorta?
A. And thoracal-abdominal aortic aneurysms, both.
Q. What is the mortality rate for descending aortic dissections in the general population?
A. The mortality rate for descending aortic dissection in the recently published IRAD study, International Registry of Acute Dissections, in patients with distal dissections that were uncomplicated and managed with medical therapy was 8

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percent. In patients with complicated dissections, distal dissections -- for example, that required an intervention or that had some complication -- the mortality was almost 30 percent.

Q. And what was the year of the IRAD study, or the publication of it?

A. It covered patients treated between '96 and '99, and I believe the year of publication was 2000.

Q. When that study makes reference to complicated dissections, does one of those complications include a dissection in the setting of a Marfan's patient?

A. I don't know how many patients with Marfan's syndrome were in that study, although the data is certainly in the manuscript.

Q. There is no separate category for mortality rates for Marfan's patients with descending aortic dissections?

A. Well, I'm sure that you could find that in the literature or pick it out of certain series, but I don't have the -- I can't quote you chapter and verse from memory.

Q. Is this a large hospital facility here, Massachusetts General?

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A. Yes.

Q. How many beds do you have?

A. A little over 1,000 acute-care beds.

Q. In your practice of vascular surgery, do you ever have occasion to refer patients out of Massachusetts General for care?

A. I can't think of ever having done that.

Q. Can you tell me, Doctor, what the protocol is at Massachusetts General for treating a patient with a descending aortic dissection?

A. Medical therapy is the treatment of choice for the majority of patients with distal dissections.

Q. And medical therapy includes what?

A. Antihypertensive therapy with beta blockade and vasodilator therapy.

Q. Anything else?

A. Those are the principal agents that are used.

Q. Do you routinely use angiography for descending aortic dissections?

A. No.

Q. When do you use it?

A. Only in very specific circumstances, where

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a particular vascular complication might need to be interrogated or treated.

Q. And would one of those complications be compromise of blood flow through an arterial vessel to a major organ?

A. Yes, it could be.

Q. And how does an angiogram help you where you suspect there may be some impediment to the flow through an artery?

A. Well, actually, it doesn't help me very much, because angiography is a diagnostic test. It's an imaging modality. And among the imaging modalities that are used in the evaluation and management of patients with acute dissection, angiography is used much, much less often than it was a decade ago, for example. And the principal imaging modality to manage patients with aortic dissection is the CAT scan. As a matter of fact, I will often operate on patients with the CAT scan alone, and I would say that on a percentage basis probably less than 10 percent of patients with dissections are being evaluated and/or treated with angiography in contemporary practice.

Q. Is that because there are risks associated

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with angiography?

A. No, because the information that one needs to obtain from an angiogram is usually available, and in many circumstances available to a better facility, with the high-quality CAT scans that we get today.

Q. A high-quality CAT scan, would that have to be done with contrast?

A. Typically it is done with contrast.

Q. And a CT done with contrast can tell you whether a vessel is patent, whether it has some flow through it?

A. Yes, it can.

Q. Can it tell you how much flow is going through a vessel?

A. It is -- neither of those tests, neither an angiogram nor a CT scan, necessarily provide quantitative information. So no, you can't measure the blood flow with that study.

Q. How do you measure blood flow through a vessel?

A. Well, you really don't.

Q. What do you use to determine whether or not there is a compromised blood flow through an aortic

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vessel to a major organ?
A. A CAT scan.
Q. And what do you look for in a CAT scan to tell you whether a patient is either at risk or is in fact suffering from compromised flow?
A. Oh, there's a whole spectrum of radiographic signs and symptoms that has to do with the topography of the aorta, the orientation of the vessel, the presence or absence of concomitant atherosclerotic disease. It's a whole variety or a gestalt, if you will, in the global interpretation of the test.
Q. So if a physician has a quality CT with contrast, he does not need to do an angiogram or any other test to determine whether or not there is an obstruction of blood flow through a vessel?
A. That's not necessarily true.
Q. Why not?
A. Because I mentioned that those studies are not -- don't necessarily give quantitative information. But today, the information available from a CAT scan generally makes angiography unnecessary, in most circumstances.
Q. Do you use Doppler ultrasound to determine

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flow rates through vessels?
A. Yes, we do.
Q. And that is one way to measure quantitatively the amount of blood flow through a vessel?
A. No.
Q. It's not.
A. No.
Q. Then why do you use it?
A. Why do we use it?
Q. I'm mixing something up, obviously.
A. We use Doppler interrogation of a lot of different blood vessels. The most common one that it's used in my practice, for example, is the carotid artery. And we use Doppler interrogation of that blood vessel to help us interrogate a percentage of narrowing in the blood vessel based on Doppler velocity shifts. So that, yes, we can estimate the degree of blockage in the carotid artery with a Doppler interrogation. We don't, personally, at this hospital, use Doppler interrogation of intraabdominal vessels because we don't need to, because we have other imaging modalities that provide more precise and better

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information.
Q. And that would be the CT?
A. CT scan.
Q. But other institutions may use a Doppler --
A. Yes.
Q. -- to evaluate --
A. Blood vessels in the abdomen. Yes, that's correct.
Q. I guess I spoke incorrectly when I said it measures flow. It really measures the degree of stenosis, if it's there.
A. You got it.
Q. And then that relates directly to obstruction of flow or not.
A. Obstruction in the blood vessel, yes.
Q. And it can only give that information to you -- that is, the Doppler finding -- in terms of the range of values; correct?
A. That's correct.
Q. And a range of 70 to 99 percent of stenosis in a vessel is significant, isn't it?
A. Yes, it is.
Q. What are the risks to a patient who has a descending aortic dissection?

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A. All of the potential complications of dissection.
Q. Which are?
A. Aortic rupture, compromise of virtually any branch of the aorta, including the intercostal vessels, which can cause spinal-cord ischemia; the arteries to the kidney, which can cause kidney failure; the arteries to the intestines, which can cause mesenteric ischemia; the arteries to the legs, which can cause profound lack of circulation to a leg. Those are the main ones with distal dissection.
Q. Now, in terms of, I guess, the risk of rupture, that is one of the reasons why you institute blood-pressure control and beta blockers; is that correct?
A. Yes, that's part of the rationale, yes.
Q. And how do you guard against dissection compromising flow to the vessels throughout the abdominal cavity?
A. The same thing: medical therapy.
Q. Do you watch for signs and symptoms that a dissection is perhaps progressing or causing compromised flow in those vessels distal to the

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dissection?
A. Yes.
Q. And how do you do that?
A. By a combination of clinical and radiographic evaluation.
Q. What are the clinical signs you watch for?
A. Well, it depends on -- I mean, the clinical signs you might watch for are absence of a pulse, for example, in the extremity; signs and symptoms of circulatory embarrassment in an extremity or a kidney or the intestine or the liver or just about any organ that is perfused from the aorta.
Q. I'm not sure what you mean by "circulatory embarrassment."
A. Inadequate circulation.
Q. And specifically, what would you look for as a physician in a patient where you have a reason to suspect compromise of, say, blood flow to the intestines?
A. What would you look for specifically?
Q. Yes.
A. You would look for the symptoms of circulatory insufficiency to the intestine, which are usually severe abdominal pain. If it

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progresses, one can have signs and symptoms of peritonitis, signs and symptoms of inability to tolerate food intake, which is an important one in patients with mesenteric circulatory embarrassment. And I'm sure there are others, but those are the main ones.
Q. I have read a number of articles, when they talk about mesenteric ischemia. They talk about the presentation is typically pain out of proportion to physical findings. Do you agree with that?
A. In some circumstances that can be the case. And what that refers to is the pain of ischemia before the ischemia has progressed to infarction, and it's only infarction that gives you the physical examination signs.
Q. How is it that ischemia causes pain?
A. Because the cirrhosal lining of the intestinal tract is exquisitely sensitive to somatic pain fibers. When I say somatic, that means something that the patient can appreciate.
Q. And the pain comes before infarction actually occurs?
A. That is the usual scenario, yes. But that time frame can literally, depending on the clinical

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circumstance, go from hours to months.
Q. And by "infarction" you mean --
A. Dead tissue. I'm sorry. Excuse me for interrupting.
Q. That's of the organ or tissue.
A. Yes.
Q. And then if we're talking about the small intestine, when you have death of the small intestines, you will have seepage of stool into the abdominal cavity.
A. If the intestine -- you don't have seepage of stool from the small intestine because there is no stool in the small intestine.
Q. The bowel.
A. The large bowel, if it perforates, you can have seepage of stool into the abdominal cavity.
Q. And when that occurs, the rate of mortality is extremely high, isn't it?
A. Yes, ma'am.
Q. When you talk about today's high-quality CTs, are you talking about 2000, 2001, 2002, or are you talking just 2003?
A. No, the basics of what we have in CAT scanning today has been available for years.

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Q. I think I lost my train of thought. We were talking earlier about management of a patient with a descending aortic dissection, and you talked about medical management -- blood pressure, beta blockers, things like that. You also talked about CTs.
A. CT scan.
Q. CT scans. What is your practice or protocol in regards to using CT scans to monitor the status of a patient with a descending aortic dissection?
A. Well, we typically get the CAT scan with contrast as our principal diagnostic imaging modality, and we usually get that right up front, you know, within -- it's really the test that we get. So we get that shortly after patient presentation.
Putting that together and monitoring the patient, it may or may not be necessary to get another CAT scan within days, or it may not be necessary to get another CAT scan during that admission, and they might not have another CAT scan for one, two, or three months.
Q. Is it important in treating a patient with

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an aortic dissection to get an early diagnostic image?
A. I believe it is, yes.
Q. And I assume, depending on how the patient fares after the initial CT scan, you may or may not, as you've mentioned, need to do any additional CT scans.
A. That's correct.
Q. Continual pain or increasing pain, would that be an indication to you to do another CT scan?
A. No, not necessarily, and it very much depends on the type of pain that you're talking about, because most patients with acute dissection will have pain at presentation and may have pain for days and they may have pain throughout their course. As a matter of fact, we wrote a little paper from here on the lack of significance of recurrent or persistent pain in patients with aortic dissection. And there's all sorts of pain. There's back pain, there's chest pain, there's abdominal pain.
Q. What type of pain or pattern of pain would you have to see in a patient with an aortic -- descending aortic dissection that would prompt you to do further imaging studies?

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A. If I felt the pain suggested a change in the circulation compared to what was shown on the initial CAT scan.
Q. That may have to do with the intensity of pain or the location of pain?
A. All of those things, because -- if I can just finish the comment.
Q. Sure.
A. Remember, if a dissection proceeds from the chest through the abdomen, there is a lot of pain from the aorta itself due to the inflammation and the stretching of the adventitia. So one expects a patient who has a dissection proceeding through the chest and the abdomen to have some degree of chest and abdominal pain as a function of the dissection itself.
Q. Could they also complain of back pain in that type of a setting?
A. Yes, ma'am.
Q. And that back pain they're feeling is actually the aortic dissection that's occurring.
A. Yes, ma'am.
Q. The actual tearing of the vessels.
A. Yes, ma'am.

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Q. Can you tell me what you reviewed in terms of formulating your opinions in the care relative to John Woyma?
A. I think I have it written down in my report here. Original X-rays performed during the interval of 10/21 to 11/4; medical records, including those from the original hospital, which was either Metropolitan or Cleveland Metropolitan -- I reviewed an emergency-room record there; and the medical records from the Cleveland Clinic; and the deposition of Drs. Daniel Clair and Timur Sarac. And I reviewed the report of plaintiffs' expert, David N. Follett, and the chronology kept by the Woyma family.
Q. Do you have a file on this case with you here today?
A. Yes, ma'am.
Q. May I see it, please?
A. Sure. I will add that this just came, and I haven't reviewed it.
Q. What is this?
A. I think it's the deposition of Follett.
MS. EKLUND: Off the record.
(Discussion off the record.)

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MS. EKLUND: We'll go back on the record.
Q. Doctor, we just took a short break, and I looked through the manila folder which you have concerning John Woyma's case. You've represented to me that this folder is all that you have concerning John Woyma, and that would include the deposition of Dr. Follett, which you've received but not yet read.
A. That's correct.
Q. But you do recall that you had an opportunity to review the entire medical chart for John Woyma?
A. Yes, ma'am.
Q. And did that medical chart include only the admission beginning October 20, 2000, to the time of Mr. Woyma's death?
A. I believe that's correct.
Q. And it's also my understanding that you've discarded those records since your review.
A. Yes, ma'am.
Q. Doctor, I notice that your report, which is dated January 11, 2000, apparently was originally done with a paragraph -- although the pages aren't numbered, it would be Page 3 -- wherein you made

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comments concerning Dr. Follett and Dr. Follett's report.
A. That's correct.
Q. And that paragraph has been marked out in red ink; correct?
A. That's correct.
Q. And then you rendered a second report deleting that paragraph.
A. That's correct.
Q. I have to assume that when you drafted your first report you sent it to Mr. Jackson and it was at his request that you deleted the paragraph relative to Dr. Follett.
A. That's a correct assumption.
Q. Did Mr. Jackson ask you to make any other changes or corrections to the original report which you wrote?
A. No, ma'am.
Q. Do you have any understanding as to why it was that Mr. Jackson asked you to delete that paragraph in your report?
A. I think his exact words were, "We don't need to teach Dr. Follett about dissection."
Q. Is it your practice, when you're working as

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an expert witness for an attorney, to have them review your reports before you put them in final form?
A. I send them a report. And I guess I have been asked on other occasions whether I would or would not include something in, and this isn't the first report that I amended at the request of the attorney.
Q. I also note there's a bill to Mr. Jackson dated January 13, 2003, for your services -- I guess some of your services, because it amounts to $1,150. That would not include the $3,000 for the initial review; correct?
A. I'll have to look at it to see. (Pause.)
That would not include my original fee for reviewing the record, although my original fee at that time was probably $2500, not 3,000.
Q. And then lastly, you have included in here the narrative which Mr. Woyma, the father, kept regarding his son's hospitalization at the Cleveland Clinic; correct?
A. That's correct.
Q. And there are some handwritten notes as well as some underscoring, which I presume you did.

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A. I'll have to look at it. I don't know.
(Pause.)
All of these are mine, except I don't know what this notation that says "get records" up here means. That's not my handwriting.
Q. That's not yours, that's mine. But everything else is yours.
A. Yes, ma'am.
Q. And I'm assuming you had some -- well, let's just talk about it. The first one -- Mr. Woyma, the father, is talking about the need for emergency surgery that he thought was the concern from the original hospital, and you write "error." My assumption is you disagree with emergency surgery.
A. Let me see it. (Pause.)
I don't know what the context of my comment means there, whether or not I disagreed --
I certainly do disagree with that opinion, so I think that's probably a correct assumption on your part.
Q. Page 3 of Mr. Woyma's notes, you circle November 1st, and you wrote -- you tell me what you wrote. I may misread it.

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A. I have two notations -- three on this page. One says "note," and pointing to an arrow: "John ate solid food and seemed to be in better spirits and even looked better." And then I have another notation that says, "Ate," referring to the fact that John went and ate a pizza or parts of a pizza.
Q. And the first notation, what did you write on the side there?
A. "Note," with an arrow to it.
Q. Just "note." All right. And of course, from your report I know that you believe it's significant that he was eating solid foods on those dates; correct?
A. Yes, ma'am.
Q. Because, if I'm correct in my recollection of your report, a patient with mesenteric ischemia cannot eat solid foods.
A. That's correct.
Q. When you say he cannot eat solid foods, do you mean he can't even begin the process of eating them, or does he eat them and they come back up?
A. The specific thing that I mean is that a patient who is having significant mesenteric ischemia will have a revulsion to food and/or an

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attempt to take food in may precipitate severe pain, vomiting, and sometimes diarrhea as well.
Q. If the mesenteric ischemia is not complete at that point, would he be able to consume food?
A. No.
Can I ask you a question? What do you mean by "mesenteric ischemia complete"?
Q. I guess to the point of infarction.
A. Okay. Mesenteric ischemia, which is a lack of circulation that has not progressed to infarction, will disallow the intake of food. By the time the patient has got to the stage of infarction, they're usually so sick that the taking of food is not part of the picture.
Q. From your review of the records, how was John Woyma eating on all of the other days during his admission at the Cleveland Clinic?
A. I don't remember day by day.
Q. Is it your general impression that he was eating and taking in nutrition, eating solid foods, during the course of his stay there until he became acutely ill?
A. Could I refer to my report?
Q. Sure.

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(Pause.)
A. "I think it is important to emphasize -- Do you want to ask a question? I think you did ask a question.
Q. Yes.
MR. JACKSON: Just so the record is clear, Doctor, are you reading when you say that?
THE WITNESS: I am reading from my report.
Q. Go ahead, Doctor.
A. Quote, "I think it is important to emphasize that the patient was eating solid foods during this point in his hospital course. In fact, I note that as late as November the 1st and November the 2nd the family's own chronology indicates that John 'ate solid food' and including pizza on November the 2nd."
Q. So from that am I to assume that he was eating solid foods up until at least November the 2nd?
A. I quote once again from my report: "In fact, I think that the enteral nutrition" -- that means eating -- "that the patient was taking during his hospital course is consistent with the medical

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approach at the Cleveland Clinic Foundation that manifest mesenteric ischemia did not become evident until very late in the patient's course."
Q. Would you explain to me what you mean by that last sentence, how his nutrition is consistent with the medical approach. I don't understand what you're saying there.
A. What I'm saying is that the overall approach to his care, in terms of how it was managed with medical therapy, is consistent with the fact that mesenteric ischemia was not a problem until very late in the patient's course.
Q. For people who aren't quite as sophisticated medically, does that mean if a doctor suspects that mesenteric ischemia is involved, a patient will not be allowed to eat solid foods?
A. No, I don't think that's correct. As a matter of fact, in patients with dissection who we are concerned about mesenteric ischemia, we will often use the taking of enteral nutrition -- that is, oral food intake -- as a diagnostic test of sorts. So that no, we will not prohibit food. But I have had a number of patients with mesenteric ischemia from dissection where I literally made the

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decision to intervene or operate based on their inability to tolerate solid food.
Q. And again, I know you've quoted your report, but I want to be clear, that it is your impression, then, that Mr. Woyma was taking in solid foods up until at least November the 2nd during his stay at the Cleveland Clinic.
A. That's my impression, yes.
Q. Doctor, I'd like to just have your manila folder marked and copied by the court reporter. We can figure out the logistics of it when we're finished here. I'll just set it aside. If you need to refer to your report, feel free. I'm giving it back to you.
In addition to the folder there, do you still have the films that were sent to you?
A. No.
Q. What did you do with those?
A. I don't remember. I believe I sent them back to Mr. Jackson.
Q. When was the last time you looked at the films?
A. It was about the time that this report was prepared.

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Q. Would that also have been the last time you looked at the medical records?
A. I believe it would have been.
Q. Doctor, how do you define the acute abdomen?
A. The acute abdomen. In surgical parlance, and to my understanding, an acute abdomen is generally one with signs and symptoms that indicate that urgent surgery is needed.
Q. What are the signs and symptoms that would indicate urgent surgery is needed?
A. Well, mostly physical-exam signs, physical-exam evidence of peritonitis.
Q. And what would those be?
A. Peritonitis is an inflammation of the lining of the abdomen, which generally implies some serious intraabdominal process, and that is -- the elicitation of peritonitis is extreme tenderness on palpation and/or something called rebound tenderness.
Q. Are there any other clinical signs that would accompany the physical finding on examination, such as such as elevated white blood count, temperature?

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A. There are a whole host of other clinical parameters that would always be put in the context, in the total context, when someone was evaluating someone or making a determination of an acute abdomen.
Q. In your recollection of your review of Mr. Woyma's medical records at the Cleveland Clinic, do you recall there was a description of an acute abdomen in Mr. Woyma?
A. I don't recall.
Q. Is it your practice in your vascular setting here at the hospital that if you have a patient who has signs and symptoms of an acute abdomen to request a general surgery consult?
A. No.
Q. Do you do the surgery yourself?
A. Yes.
Q. Do you ask a general surgeon to assist in that surgery?
A. It all depends on the circumstance.
Q. In the abdominal cavity, in your practice is there any division between like the revascularization of an abdominal cavity versus removal of necrotic tissue, that a general surgeon might do?
A. There sometimes is. As a matter of fact, I did such a case Friday night and Sunday morning.
Q. Is that typical, or is it....
A. It's very individual, very individual. A vascular surgeon, such as myself, is a fully trained general surgeon, and I don't hesitate to take out infarcted or a bowel that needs to come out -- I can do that -- although I have also, as I did this weekend, done an operation and then asked a general surgeon to go ahead and tell me what he thinks and to remove some intestine.
Q. I guess, then, in the setting of one of your patients who has a descending aortic dissection who develops signs of an acute abdomen, that is a patient that you yourself would take to surgery.
A. Yes, ma'am. And I did such a thing on Friday night.
Q. Was that a descending dissecting --
A. No, it was not an aortic dissection. It was a case of mesenteric ischemia, but it had nothing to do with descending dissection.
Q. What caused the mesenteric ischemia?
A. Atherosclerotic occlusive disease.

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Q. Was that an elderly patient?
A. Sixty-three.
Q. How did you make the diagnosis on this patient?
A. From CAT scan.
Q. And what did you see on the CAT scan?
A. An occlusion of the superior mesenteric artery and the previously performed surgical reconstruction of a superior mesenteric artery.
Q. And it was a complete occlusion?
A. Yes, ma'am, it was.
Q. I don't know why I just thought of it, but in Mr. Woyma's notes, in your file, you had circled at one point where there's reference to a complaint of excruciating pain in the legs. I'm sure you don't recall it unless I find it for you; correct?
A. I think it's right on that first page.
Q. No.
A. There was a third notation on that page where I pointed out the other two.
Q. Yes, you are right. On Page 3, on 11/4, you circle and write in the margin there "leg pain."
A. I circled the sentence that said, quote, "He said his legs felt like they were being

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crushed," and I wrote an arrow that says, "Severe leg pain."
Q. What is the significance of your notation and circling of that comment?
A. You know, I don't know what the significance of it is. I think I was just making a note to myself.
Q. Would dissection into the right common ileac with compromise of flow cause that kind of leg pain?
A. A dissection with compromise of circulation to the leg could certainly cause severe leg pain, absolutely.
Could I just finish that answer? But you would also supplement that, of course, by an examination of the pulses in the leg.
Q. Is it possible for the pulses in the lower extremity to be normal but yet there is some level of ischemia going on with some compromise of flow?
A. No.
Q. So any compromise of flow will result in some diminished pulse in the lower extremities?
A. No.
Q. Can you explain.

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A. You asked the question is it possible to have pulses in the leg and still have some degree of ischemia, and I said no, because if you have palpable pulses all the way down the leg, then you don't have any significant degree of ischemia in the leg.
Q. The ischemia in the leg would have to come from compromise of the ileac vessels?
A. Or the femoral or any of the other.
Q. Somewhere below the superior mesenteric artery?
A. Or you could have obstruction at the aortic level compromising circulation to both legs from a dissection. You can have that, yes?
Q. If you don't have it at the level of the aorta but you have it somewhere --
Occlusion or compromise of blood flow through the SMA alone will not affect circulation to the legs; is that correct?
A. That's correct.
Q. So when it gets beyond the SMA, at that point it will affect circulation to the legislation.
A. It could.
Q. It could. And once it affects the

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circulation to the leg, whether it's complete or partial, you will have some diminished pulse in the lower extremities?
A. If you have a normal pulse, you can assume that the circulation to the leg is fine. If you have an absent pulse, you need to raise the question of circulatory insufficiency to the leg. It is certainly true that there are different degrees of that, but in the setting of aortic dissection, particularly in a young person, if you have palpable pulses in the leg, then the circulation to the leg is not in question or is not an issue.
Q. In a patient with a descending aortic dissection, what is the significance of a finding of blood in the stool?
A. What do you mean by "blood in the stool"? Blood visible to the eye?
Q. No, an occult finding of blood.
A. Occult finding of blood. I don't think that there's really any significance of occult finding of blood in the stool in a hospitalized patient, particularly one who is on anticoagulation therapy.
Q. Can it be a sign of ischemia to the colon

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or a perforation?
A. I would say no to both of those, because when you're talking about a sign of mesenteric ischemia, you're not talking about occult blood, you're talking about gross, manifest blood. And the finding of blood in the stool, either gross or microscopic, has nothing to do with perforation. The two are not related.
Q. When you talk about a gross finding of blood in the stool, is that of significance in the setting of a descending aortic dissection?
A. Yes, it would be. Gross blood in the stool would be a significant finding in any circumstance.
Q. And what is the significance in the setting of the dissection?
A. In a patient who has gross blood in the stool and a dissection, then one needs to be concerned about the adequacy of mesenteric circulation. And, of course, there could be other reasons for the blood in the stool, too.
Q. In terms of, I guess, guarding against or protecting a patient from mesenteric ischemia, is the most important finding that of pain?
A. The most important findings, I think, are

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related on radiographic studies.
Q. After radiographic studies, is pain or your assessment of pain in that patient the most important thing you have to go by in terms of assessing whether there is mesenteric ischemia occurring?
A. Pain is an important symptom complex to be considered in the whole clinical picture, yes -- abdominal pain.
Q. Do you have any understanding as to why John Woyma had -- what was the cause of his abdominal pain during his admission at the Clinic?
A. No, I don't. May I refer to my record here?
Q. Sure.
A. Because, as I recall, I spent some time in this report talking about his complaints of pain.
(Pause.)
Q. Did you find it?
A. Yes. I've read it.
Q. And your report refers to a severe headache and back pain; correct?
A. Yes, ma'am.
Q. Also mentions groin pain, but you thought

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right groin pain would have been more consistent with ischemia to the colon than left groin pain.
A. I refer specifically to the subsequent findings at operation, where he had infarction or severe ischemia of the right colon. A manifestation of right colon ischemia-slash-infarction can be referred right groin pain -- can be. It would be more typical for the patient to have abdominal pain. But there is throughout this a lot of talk of severe left groin pain, and I go on to say that I don't have an appropriate explanation for that even in retrospect.
Q. At findings during the operative procedure, do you recall the areas of the small intestine that were necrotic?
A. I don't recall specifically.
Q. Would necrosis on the left side of the body in the small intestine there cause left groin pain?
A. Well, the small bowel is not on the left side of the body. The small bowel is sort of in the middle. The reason that right colon ischemia-slash-infarction may cause referred right groin pain is that the right colon may lay in the right hemipelvis and cause irritation to the nerves that go down to

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the right side, just as a perforated appendicitis can cause pain in the right groin or in the right scrotum, for example. But one does not usually associate small-bowel ischemia-slash-infarction with referred pain to either groin, because the small bowel is, of course, intraabdominal, as opposed to lying in the retroperitoneal gutter, where the right colon does.
Q. What about the sigmoid colon? Where does that lie in the body?
A. It lies intraabdominal.
Q. Is it more left?
A. The sigmoid colon is on the left, yes, it is.
Q. Would that account for a complaint of left groin pain?
A. It could, if the -- although the sigmoid colon, because it's usually intraabdominal, would usually be referred to an abdominal pain.
Q. Is it your belief, based upon the report and your recollection of the record, that Mr. Woyma's principal complaint of pain was left groin?
A. I believe that that was a frequent -- yes,

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as I said in my report, his pain syndrome is usually characterized as back and left groin pain.
Q. Do you have any specific recollection of severe abdominal pain in Mr. Woyma?
A. I know that there were multiple references to abdominal pain in the family's chronology.
Q. What about in the records themselves, the medical records?
A. I don't remember specifically, other than it's detailed in my report here.
Q. You are aware that Mr. Woyma was placed on a PCA?
A. I recall that, yes.
Q. Do you recall the reason for the PCA?
A. I don't. I don't.
Q. Do you routinely put patients who come in with a descending aortic dissection on a PCA pump?
A. They frequently are treated with narcotics. A PCA pump is something that might or might not be done, depending on the amount of the patient's pain.
Q. If you have a patient on a narcotic for pain control, how do you evaluate the progression or not of his abdominal pain relative to mesenteric ischemia?

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A. It can be a problem.
Q. Have you ever put a patient on a PCA pump without knowing the cause of his pain?
A. Well, I think that it depends very much on the patient and their chronology. One can often not exactly determine what the patient's pain is related to, but it is generally important to, in your own mind or in your clinical assessment, have a judgment about what it's not related to. So that it may be legitimate to treat a symptom of pain without a definitive explanation for it as long as you are convinced that you are not either obfuscating some serious problem or interfering with the subsequent evaluation of what could be a serious problem.
Q. In a patient who is at risk for mesenteric ischemia, you would rule out mesenteric ischemia before you would put a patient on a PCA pump or give them narcotics; is that fair?
A. That's fair. That's fair.
Q. Have you in your practice had occasion to see a small perforation in the abdominal cavity that walls off?
A. Small perforation of what?
Q. Colon.

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A. Have I had occasion to see a perforation that walls off?
Q. Yes.
A. Yes, ma'am, I have.
Q. And what's the mechanism of that? Tell me what happens.
A. Well, when a viscus perforates, the body's natural reaction is to send policemen to the area, and those policemen can be both bloodborne, as in white blood cells, macrophages, and so forth, and physical structures, such as the omentum or surrounding leaves of the mesentery or other loops of bowel. So it is certainly well recognized that, for example, a perforation of the colon related to diverticulitis or a perforation of the appendix related to perforated appendicitis or a focal perforation of the colon or small bowel related to ischemia can and does wall off -- not always, but often.
Q. And the walling off we're speaking of, that's the body's attempt to, I guess, separate that harmful substance from the rest of the body?
A. To contain the process.
Q. And when that occurs, is there a, I guess,

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an alleviation of the symptoms that the perforation would otherwise cause?
A. There can be, yes. There can be.
Q. And I'm assuming further that a walling off is only a temporary measure; eventually the problem reemerges.
A. It can, depending on the disease process. It's not at all uncommon for a walled-off diverticular abscess to be treated adequately with antibiotics for a period of time and then the surgery deferred for two or three months. So it's quite a spectrum, depending on the particular disease process and the patient and so forth.
Q. A walled-off -- a small perforation of the colon, would that be something you could pick up on a CT scan?
A. A CT scan would be a good test for that.
Q. Is it always reliable that way?
A. Well, never say "never" and always avoid "always." But if I had to choose a test to pick up or to evaluate a patient for a potential "small" perforation, it would be a CT scan.
Q. Doctor, why do you suppose Dr. Clair elected to do an angiography in Mr. Woyma?

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A. May I refer to my report?
Q. Sure.
A. I'm sorry, would you repeat the question?
Q. My question is, why do you suppose, or do you have any reason to know, why Dr. Clair elected to do an angiogram in Mr. Woyma?
A. Yes, because I think he wanted to put that information together, and -- according to my report here, the angiogram was obtained approximately ten days after admission. He wanted to put that information together with the information from multiple CAT scans to assess what the potential problems were and what the potential treatment options were, should treatment be needed.
Q. But you have earlier testified that an angiogram is unnecessary in the setting of an aortic descending dissection.
A. No, I never said it was unnecessary. I said in contemporary practice I rely on the CAT scan and that angiography is in fact infrequently used in the evaluation of our patients with aortic dissection.
Q. And you've had a chance to review the CT scans that were taken of Mr. Woyma prior to the

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angiogram that Dr. Clair did; correct?
A. Yes, ma'am, I have.
Q. And do you believe that those CT scans were adequate to assess Mr. Woyma's status in terms of the dissection and stenosis of the superior mesenteric artery?
A. They were adequate to answer the question of whether or not he needed an acute intervention in the first day or two of his admission to the hospital.
Q. Could a CT scan have given Dr. Clair just as much information as the angiogram did on October 31st?
A. Well, I can't answer that in that particular case because I wasn't caring for that patient. I have certainly done angiograms on patients with acute dissection because I felt we either needed more information or I wanted to assess the patient, for example, for the feasibility of an endovascular intervention.
Q. And an angiogram is a proper vehicle for assessing the potential for endovascular intervention?
A. Yes, ma'am, it is.

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Q. And it was Dr. Clair's intention to do an endovascular intervention in Mr. Woyma; is that correct?
A. Well, I think it was one of the things that he was considering, as revealed from my review of the records, yes.
(Discussion off the record.)
Q. Back to that section of your report, Doctor, where you talk about the angiogram that Dr. Clair did, and you comment, "And while there is some stenosis noted in the origin of the superior mesenteric artery, this is not considered to be flow-limiting or in need of immediate correction."
A. Yes.
Q. What is your basis for saying that it was not considered to be flow-limiting or in need of immediate correction?
A. Based on the interpretations as revealed in the medical record and my own review of the angiogram.
Q. And your interpretation of the records, are you making that judgment based on what was or was not done for Mr. Woyma?
A. No, on what was stated in the medical

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record as the interpretation of the findings of the arteriogram.
Q. Did Dr. Clair in his findings on the angiogram make any comment regarding the flow through the SMA?
A. Well, I think that I just answered that in saying that -- I'm quoting from my report: "Dr. Clair performs an angiogram, and while there is some stenosis noted in the origin of the superior mesenteric artery, this is not considered to be flow-limiting or in need of immediate correction."
Q. So it's your belief that his report actually says those words or words to that effect; is that correct?
A. Yes.
Q. And obviously, if the findings in the angiogram did not suggest flow limitation, there would be no need to consider a stenting procedure for this patient.
A. That's correct.
Q. Doctor, at one point in Mr. Woyma's stay there is a nursing note of coffee-ground emesis with bloody stool. What is the significance of coffee-ground emesis?

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A. Coffee-ground emesis with bloody stool?
Q. Yes, let's just talk about vomiting coffee-ground emesis. What does that indicate to you in a patient such as Mr. Woyma?
A. "Coffee ground" is a visual description of something. It may be blood. It may be partly digested material. So that description itself does very little for me.
Q. How about if I add hypoactive bowel sounds, foul-smelling vomit noted by a nurse, abdomen tender, slightly distended, nasogastric tube draining thick, brown, bilious drainage? What does that picture give you?
A. A nasogastric tube, if dropped into someone's stomach, would be expected to drain thick, brown, bilious material.
Q. The rest of the clinical picture there?
A. Are you reading from --
Q. I'm reading from my notes, but I'll -- under Day 18, under Nursing, at 0800.
MR. JACKSON: What did you just hand him?
MS. EKLUND: That's the flow sheet.
A. So the nursing notes says, "Vomiting

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coffee-ground emesis, guaiac positive." It says, "Dr. Wang aware of hypoactive bowel sounds. What is vomiting is foul-smelling."

MR. JACKSON: The date on that is November 6th?

THE WITNESS: November 6th.

Q. Does that mean anything to you from a clinical standpoint?

A. No, it doesn't, because it was a notation made by a nurse, and it just doesn't have any significance for me.

Q. Because it's made by a nurse?

A. No, because it was -- I mean, it's impossible for me to assign any significance to a note that was made by a nurse or a resident or an intern, because those sorts of notes -- vomiting coffee-ground material, abdomen distended, hypoactive bowel sounds -- you could walk through this hospital now and find four or five hundred patients where a nurse might have written that in the chart. So it doesn't have a whole lot of significance to me.

Q. I'm going to hand you back the flow sheet, Doctor, and ask you to look at Day No. 9, October

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28th, and read the SICU note written by a physician right here.

MR. JACKSON: Again, that's the flow sheet you prepared?

MS. EKLUND: Yes.

A. "SICU note: Left groin pain, abdomen rigid, ND" -- that means nondistended -- "hypoactive bowel sounds, tender in lower quadrant, plus peritoneal signs, spiked temperature last night for first time, pan culture."

Q. Is that consistent with an acute abdomen?

A. It could be consistent with an acute abdomen, yes.

Q. One more day, Doctor. Just bear with me. Day No. 10, which is the following day, the SICU note again.

MR. JACKSON: Again, reading from your flow sheet.

MS. EKLUND: Yes.

A. There's a note that you've underlined that says, "Possible stenting Monday. Exam: Abdomen rigid, nondistended, positive bowel sounds. Right greater than left quadrant tenderness. Question involuntary guarding." This doesn't all make a lot

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of sense, does it? Because if you really believe that the patient had peritonitis the day before, you would have operated on them.

Q. Somebody would have, wouldn't they?

A. Well, someone would have evaluated the patient, and if the doctors in charge felt that he had peritonitis, I think that he would have been operated on.

Q. But do you agree that the description on those two days is indicative of an acute abdomen, if it's correct?

A. If it's correct, it could be consistent with an acute abdomen.

Q. It certainly would warrant a surgical consult?

A. It would warrant a more senior person -- I don't know who made these notes. Can I ask that?

Q. An SICU physician.

A. An SICU physician. So we don't know if it's an anesthesiologist. We don't know if he's a resident or anything else like that, do we?

Q. No, but we know he's a physician working at the clinic who is examining the patient, providing medical care. We have to assume some level of

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competence, don't we?

A. I don't assume anything. So if someone calls me from the ICU and says, "Your patient has peritonitis to my exam," I go down there and examine him. If I agree that they have peritonitis, I operate on him. But if I disagree that they have peritonitis, I say, "I disagree," and I don't operate on them.

Q. And when you disagree, do you chart your disagreement in the patient's record?

A. Oh, I might or I might not. I don't do much charting in the medical records these days.

Q. You leave that to your residents to do?

A. I do, most of the time.

Q. I think I'm just about finished, Doctor. Just give me a minute to look at my notes, if you can.

(Discussion off the record.)

Q. Doctor, I don't have anything else for you. Can I give your file to the court reporter to copy and send back to you?

A. I don't see why not.

MS. EKLUND: We'll mark this Exhibit Cambria 1.

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(Exhibit Cambria 1 marked for identification.)

(7:16 p.m.)

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REPORTER'S CERTIFICATE

Commonwealth of Massachusetts)
County of Suffolk)

I, Alan H. Brock, Registered Professional Reporter and Notary Public in the Commonwealth of Massachusetts, hereby certify that there came before me on October 29, 2003, at the time and place specified above, Richard Paul Cambria, M.D., the deponent herein, who was duly sworn by me to testify to the truth and was thereafter examined under oath by counsel.

I certify that the questions asked of the deponent and the answers given were taken down by me stenographically and transcribed by me using computerized translation software; and that the foregoing is a true and accurate transcript thereof.

I certify further that I am not counsel, attorney, or relative of any party litigant, nor otherwise interested in the event of this suit.

____
Alan H. Brock, RDR/CRR

DATED: __________ My Commission Expires 04/28/06

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Richard Paul Cambria, M.D.

SIGNATURE PAGE / ERRATA SHEET

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I have read the foregoing transcript of my deposition on October 29, 2003. Except for any corrections or changes noted above, I hereby subscribe to the transcript as an accurate record of the statements made by me.

Signed under the pains and penalties of perjury.

Deponent:______________________________ /___/2003
Richard Paul Cambria, M.D.

Notary Public: ________________________ /___/2003

in and for: ____________________________

My commission expires: __________________

Richard Paul Cambria, M.D.

SIGNATURE PAGE / ERRATA SHEET INFORMATION

For deposition taken on October 29, 2003

Janet Woyma et al. v. Cleveland Clinic Foundation

SIGNATURE INFORMATION FOR COUNSEL

The original of the Errata Sheet has been delivered to John V. Jackson, Esq. When the Errata Sheet has been completed by the deponent and signed, the original thereof should be delivered to Claudia R. Eklund, Esq., to whom the original deposition transcript was delivered.

WITNESS INSTRUCTIONS

After reading the transcript of your deposition, please note any change or correction and the reason therefor on the errata/signature page. DO NOT make any notations on the transcript itself. If necessary, continue the format on a separate page. PLEASE SIGN AND DATE (before a notary if requested) the errata sheet.