In The Matter Of:

Herbert D. Dawson, et al. v.
Medina General Hospital, et al.

A. Lawrence Cervino, M.D.
August 23, 2001

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IN THE COURT OF COMMON PLEAS
MEDINA COUNTY, OHIO

HERBERT D. DAWSON, et al.,

Plaintiffs,

-vs- CASE NO. 01 CIV 0166

MEDINA GENERAL HOSPITAL, et al.,

Defendants.

Deposition of A. LAWRENCE CERVINO, M.D., taken as if upon cross-examination before Aneta I. Fine, a Registered Merit Reporter and Notary Public within and for the State of Ohio, at the offices of Crystal Clinic, 3975 Embassy Parkway, Akron, Ohio, at 6:30 p.m. on Thursday, August 23, 2001, pursuant to notice and/or stipulations of counsel, on behalf of the Defendant, Manuel C. Abellera, M.D., in this cause.

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Jeffrey R. Kontak, M.D.

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(Thereupon, Defendant's Exhibit 1 was marked for purposes of identification.)

A: LAWRENCE CERVINO, M.D., of lawful age, called by the Defendant, Manuel C. Abellera, M.D., for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF A. LAWRENCE CERVINO, M.D.

BY MS. LOESEL:

Q: Dr. Cervino, my name is Pam Loesel and I represent Dr. Abellera in this case and I thank you for coming today. And I first need to know if you've ever been deposed —

A: Yes.

Q: — in the past. Okay. Since you have been deposed I'll just briefly go through some of the things I need you to do as far as the taking of this deposition.

I'll be asking you several questions and the court reporter is going to be documenting your responses. If I ask you any no or yes types of

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questions, I do need you to respond verbally.

A: Correct.

Q: So that the court reporter can get that information down. Also if I ask you a question that's unclear I will ask that you please ask me to restate the question, to rephrase the question and let me know that the question is unclear. Will you do that for me?

A: Yes.

Q: Okay. And if you do not ask me to rephrase a question then I will assume that you've understood the question and will proceed to answer, correct?

A: Correct.

Q: And the last thing is if you need me to stop or take a break, if you get paged and need to respond to a call, please let me know, we'll stop and let you go ahead and take care of what you need to, okay?

A: Correct.

Q: Okay. I'll try to be as brief as possible. I know we're all on tight schedules.

First off, can you state your name for the record, please?

A: Lawrence Cervino.

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Q: And what is your current work address?

A: Crystal Clinic, Embassy Parkway.

Q: And what is the address?

A: Akron — 3975.

Q: Okay.

A: Embassy Parkway, Akron.

Q: And is that your only office?

A: I have satellite offices.

Q: And where are those located?

A: Medina, Wooster and Alliance.

Q: And what percentage of your time do you spend in the Akron office?

A: 50 percent.

Q: Okay. And the Medina office?

A: 20 percent.

Q: Okay. And what about Wooster and Alliance?

A: 20 percent in Wooster, and 10 percent, Alliance.

Q: Okay. And what is your profession?

A: Plastic surgery.

Q: Okay. And are you Board-certified?

A: Yes.

Q: In any specialty?

A: Yes.

Q: And what areas are you Board-certified in?

A: I have Board-certification in general surgery

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which was a prerequisite when I trained for plastic surgery. Plastic and reconstructive surgery and hand surgery. Reconstructive hand surgery.

Q: Now, those are three separate certifications then, is that correct?

A: Correct.

Q: Okay. What area of practice do you spend most of your time in?

A: I have a varied practice but I would say one-third is hand.

Q: And that would be reconstructive hand surgery?

A: Correct. Acute and reconstructive.

Q: Okay. And by acute, what do you mean?

A: Injuries. Hand injuries and secondary reconstruction.

Q: Okay. And your reconstructive work on the hand would be what type of work?

A: It's —

Q: Primarily plastic surgery?

A: Everything, bone, joint, tendon, nerve, reconstruction in addition to soft tissue reconstruction.

Q: Okay.

A: It's a very broad field. There's a three volume

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book just on reconstructive hand surgery. It includes Congenital Hand, which are birth defects, Traumatic Hand, tumors in the hand. Traumatic Hand is unquestionably the largest because this involves tendon reconstruction, bone reconstruction and nerve reconstruction.

Q: Now, you said this was approximately one-third of your work. What are the other two thirds of your work?

A: One third may be skin tumors, cancers.

Q: And would this be specifically located on the hand again?

A: No. Anywhere in the body.

Q: And the other third?

A: Would be a combination of reconstructive surgery for post-traumatic defects from injury, breast reconstruction, some cosmetic surgery.

Q: So the other third would consist of all of those areas?

A: All of those, right.

Q: Are you licensed in the State of Ohio?

A: Yes.

Q: And any other state?

A: No.

Q: And are you currently part of a partnership or a

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solo practitioner?

A: Partnership.

Q: And your partnership is with whom?

A: Dr. Wells, W-E-L-L-S, and Dr. Pennington, P-E-N-N-I-N-G-T-O-N.

Q: And what is the name of your group?

A: Crystal Plastic Surgeons.

Q: And how long have you been with this group?

A: I've had Crystal Plastic Surgeons for the last 12 years.

Q: And where were you prior to that?

A: Individual private practice, primarily based at Children's Hospital in Akron.

Q: And was your work at Children's Hospital just with children?

A: No.

Q: Or were you also working with adults at that time?

A: Adults and children.

Q: What percentage of your current practice is children versus adults?

A: Oh, ten percent children only.

Q: Okay. And where did you attend medical school?

A: Columbia University, New York.

Q: And when did you graduate?

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A: 1964.

Q: And where was your internship and residency?

A: I interned at Case Western Reserve, University Hospital, and did residency in general surgery at the University of Pittsburgh. I did plastic surgery residency at the University of Rochester in Rochester, New York, and I did a reconstructive fellowship in hand surgery at Wayne State University in Detroit.

Q: Where are your hospital staff privileges at?

A: At all the Akron hospitals except Cuyahoga Falls.

Q: And by all Akron hospitals, are you saying Akron General and Summa?

A: Akron General, Summa, Barberton, Children's. Also on the staff at Medina, Wooster, Wadsworth and Alliance.

Q: Okay. Are these all full privileges or courtesy privileges?

A: I'm courtesy privilege at Wooster but full privileges at all other hospitals.

Q: Okay. Have you published anything —

A: Yes.

Q: — Dr. Cervino. And I don't think Murray had requested a copy of a CV.

A: We'd be happy to forward it to you.

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Q: Would you, please? I'd appreciate that.

Do you do any teaching?

A: Yes. An associate professor.

Q: At what school?

A: Northeast Ohio University College of Medicine.

Q: And what do you teach there?

A: Anatomy, and I teach residents in plastic surgery here under the umbrella of the university.

Q: So you would have a resident here working in your office with you?

A: Yes.

Q: And supervise that resident?

A: Today I had a medical student in my office who happened to be from Case Western Reserve but he's with me for the month.

Q: Okay. So you also do some work with Case along with NEOUCOM?

A: Correct.

Q: You provided me with a copy of your medical record of Mr. Herbert Dawson who is the plaintiff in this case. I'm going to hand you this copy, Dr. Cervino, and ask you to look at it briefly, and identify that for me as a copy of your medical record of Mr. Dawson.

A: It appears to be a medical record, correct.

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Q: Okay. And we've marked that as Defendant's Exhibit No. 1.
A: Sure.
Q: Is there, this is a complete copy of your chart then?
A: I'd have to look at my chart. I believe it is.
Q: Okay. I will hand you your chart so you can look through it and verify that for me.
A: It is my chart except for the correspondence regarding this deposition.
Q: Okay. And how many letters did you have with regards to the deposition in your chart.
A: Three letters. Correct. Four letters.
Q: Okay. Your chart includes some records that are not records that you generated, is that correct?
A: Correct.
Q: Okay. And what would those records include that you've received from outside hospitals or physicians' offices?
A: They would be copy of nerve conduction studies ordered by Dr. Kontak in Wadsworth.
Q: And that would be the only other piece of information?
A: Medical information, correct.
Q: Okay. Do you have any records from hospitals?

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A: No.
Q: At all. Okay. Did you review that study from Dr. Kontak prior to seeing Mr. Dawson?
A: I can't recall.
Q: Okay. So you don't know when that record arrived?
A: I have no idea.
Q: And when it was placed into your chart?
A: That's correct.
Q: When did you first see Mr. Dawson as a patient?
A: December 12th — I'm sorry, December 20th, 1999.
Q: And who referred Mr. Dawson to you?
A: Dr. Kontak.
Q: And who is Dr. Kontak?
A: He's a primary care physician with offices on High Street in Medina. I'm sorry, in Wadsworth.
Q: Have you had other referrals from Dr. Kontak in the past, Dr. Cervino?
A: Yes.
Q: And did you have a conversation with Dr. Kontak prior to seeing Mr. Dawson as a patient?
A: I can't recall.
Q: Okay. So you don't recall if he verbally gave you any history about Mr. Dawson?
A: That's correct.

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Q: Okay. Now, when you see a patient, Dr. Cervino, what is your usual practice as far as assessing and evaluating that patient?
A: I take a history from the patient.
Q: Okay. And what does that history usually consist of?
A: Their main complaint, and any other pertinent information that the patient offers regarding that main complaint. It's a focused history.
Q: Did you take a history of Mr. Dawson?
A: Correct.
Q: On the 20th when you saw him?
A: Correct.
Q: And who did you obtain that history from?
A: The patient.
Q: Okay. And how do you know that?
A: He told me.
Q: Is that documented in your notes, that the information came directly from the patient and not from a family member?
A: I can't recall. As far as I know it came from the patient.
Q: Okay. And following the taking of a history then is it your practice to do a physical examination of the patient also?

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A: Correct.
Q: And what does your physical examination usually consist of?
A: It's generally limited to the area of complaint.
Q: Okay. And in this case what would that be?
A: It would be his upper extremity on the left.
Q: Now, when you say you limit it to that area, does that essentially mean that that is the only examination you do then, that you did not look at any other aspects of the patient, any other parts of their body as part of the physical examination?
A: Generally, yes.
Q: Okay. So in the case of Mr. Dawson, you would have only looked at the upper extremity on the left side?
A: Correct.
Q: And that would essentially be what parts of his body?
A: What parts of — I don't understand your question.
Q: Okay. I guess I'm asking would that purely be his left arm or would that entail more than his left arm and hand?
A: It would be the left arm from the shoulder down.

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Q: Okay. And you wouldn't be looking at his chest, his neck, his spine, anything like that?
A: No.
Q: Okay. Now, I have a copy here as part of your record of a note that was made on 12-20-99. Is that, again, the note that you made of your history and physical examination of Mr. Dawson?
A: Correct.
Q: Okay. And if you could tell me, Dr. Cervino, what information in this note is the history portion of your note. If you could just read that part to me, please.
A: I can read you the history. 52-year-old gentleman recently hospitalized at Medina Hospital for acute diverticulitis for which he was hospitalized for a week with intravenous antibiotics followed then by a left colectomy by Dr. Abellera. While he was in the hospital he apparently had an infection at the IV site in the dorsal aspect of his left hand with lots of inflammation and is now left with acute reflux sympathetic dystrophy. He says he has lost control of his left little and ring fingers and is extremely hypersensitive in the whole hand but particularly along the ulnar side. That's the

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history.
Q: Okay. So all of that information you just read to me is history that was given to you by Mr. Dawson, is that correct?
A: Correct.
Q: Okay. And would that history include the statement that he has acute reflux sympathetic dystrophy?
A: No.
Q: Okay. That was not part of the history that he gave you?
A: No.
Q: Okay.
A: He just related to me that, the hypersensitivity of the hand.
Q: Okay. What would the statement that he has acute reflux sympathetic dystrophy, where would that have come from?
A: My assessment.
Q: Okay. So that would be your diagnosis?
A: Correct.
Q: Okay. Dr. Cervino, can you tell me what acute reflux sympathetic dystrophy is?
A: It's one of the causes of upper extremity or lower extremity, you can have it as well, pain.

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It is a basket term into which mirrors several pain patterns, one of which is hyperactivity of the sympathetic nervous system.
Q: Okay. And what is hyperactivity at the sympathetic nerves?
A: Hyperactivity means increased activity.
Q: How do you determine that?
A: Partly by physical exam.
Q: Okay. And what would you be looking for in that physical exam?
A: Evidence of swelling, redness, inflammation, hypersensitivity, increased sweating confined to the extremity, predominantly on the medial or ulnar side of the extremity.
Q: Okay. When you did the examination of Mr. Dawson, did you find swelling?
A: Correct.
Q: What kind of swelling did you find?
A: Soft swelling.
Q: And where was the swelling located?
A: In the whole hand.
Q: And what hand would that be?
A: Left hand.
Q: Was the swelling confined to the hand or was it into the arm area?

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A: I can't recall.
Q: And did you find redness when you did an examination of Mr. Dawson?
A: Yes.
Q: And where was the redness located?
A: Primarily on the ulnar half of his hand.
Q: And when you say the ulnar half —
A: That is the —
Q: — what side is the ulnar?
A: The little finger side.
Q: And where was that redness confined, just to the finger, into the hand; do you recall?
A: Finger and hand.
Q: Both areas?
A: Right.
Q: Did it extend into the wrist?
A: I can't recall.
Q: Okay. And you also mentioned that — was there inflammation with Mr. Dawson?
A: Yes.
Q: And where was that inflammation located?
A: In the same area as the swelling, primarily on the little finger side of the hand as evidenced by increased redness and warmth.
Q: Okay. And you also mentioned that there's a

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possibility of hypersensitivity. Did you find that with Mr. Dawson?
A: Yes.
Q: And where was that?
A: Again, primarily on the ring and little fingers.
Q: And how did you determine that there was hypersensitivity?
A: By physical contact. And by history.
Q: And what history indicated that there was hypersensitivity?
A: Patient said that they were very sensitive.
Q: Okay.
A: And they were sensitive to touch.
Q: Okay. And did you find, through your examination, that his hand was sensitive to touch?
A: Yes.
Q: Okay. Now, you also said that you can diagnose reflux sympathetic dystrophy partly by physical exam?
A: Correct.
Q: What is the other way?
A: The best way is to do what is known as a sympathetic block in the neck called a stellate, S-T-E-L-L-A-T-E, stellate ganglion block.

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Q: Now, this is for diagnostic —
A: And therapeutic.
Q: — purposes?
A: But it's a very good diagnostic test.
Q: How is it used as a diagnostic test?
A: If the patient responds and improves then it's considered to be related.
Q: And if the patient doesn't respond?
A: Then you look for other sources.
Q: So that would rule out reflux sympathetic dystrophy as a diagnosis?
A: Not completely.
Q: Why not?
A: Because some patients with reflux sympathetic dystrophy don't respond to stellate ganglion blocks, though most do. We never use, say always or never.
Q: How many blocks would have to be done in order to make that determination?
A: You'd have to talk to an anesthesiologist but I would say, and I obviously, I don't do them. I would do several blocks.
Q: What area of the body does reflux sympathetic dystrophy usually affect?
A: Affects primarily the extremities, primarily

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upper extremity, but it can occur in the lower extremity as well, though less often.
Q: Now, by extremities, are you limiting it purely to the feet and the hands or would it also include the arms and/or shoulders?
A: Can include arm and shoulder.
Q: But not necessarily?
A: That's correct.
Q: Okay. Are there other names for RSD?
A: There's got to be a hundred different names.
Q: There are?
A: Right.
Q: Do you know what —
A: I can send you a list.
Q: You can?
A: Right.
Q: Okay.
A: I've lectured on this subject. There's a whole list of names over the years, but generally we call it reflux sympathetic dystrophy, but some pain patterns of unknown cause have been placed in the basket of reflux sympathetic dystrophy.
Q: But they're really not RSD then?
A: Probably not.
Q: And how do you make that determination, that

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they're really not part of RSD?
A: Various tests, for example, such as stellate ganglion blocks, three-phase bone scans.
Q: What is a three-phase bone scan?
A: There is a, where radioactive dye is inserted, injected and then is, bone is scanned in the extremity and there are three phases to the scan.
Q: What are those three phases?
A: You have to talk to the radiologist about it to get all of the exact details, but it's a phase where you see, you see pre-vascular, you see early appearance of the radioactivity, and then you see a delayed phase as the dye leaves, and then a third phase where certain amount of radioactivity or vascularity persists and it's called a three-phase bone scan. Each bone scan is generally, has three phases and reflux sympathetic dystrophy has a fairly characteristic phase.
Q: Do you know what that characteristic phase would be?
A: No. I'm not an expert on reflux sympathetic dystrophy.
Q: Okay.
A: But the, but if you want all the information, you

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have to get from, combination of, get this information from the radiologist who does the three-phase bone scans and from the anesthesiologist who treats the disease.

Q: Now, if there's a normal bone scan would that rule out reflux sympathetic dystrophy?

A: No.

Q: Why not?

A: Because no single test can completely rule it out.

Q: Would a combination of these tests rule it out?

A: Generally it's helpful, yes.

Q: So if you had a normal bone scan and along with the —

A: Failure —

Q: — blocks not working, that would be more likely than not indicative that this is not the correct diagnosis?

A: That's correct.

Q: Okay. Now, you said that these were two of the ways of diagnosing. Is there more than the three-phase bone scan or the nerve blocks?

A: Those are the most common.

Q: What are some other ones that —

A: There are medications that you can inject.

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Q: And what would those medications be?

A: I would have to give you a list.

Q: Okay. And —

A: Where various medications are injected. To test the response.

Q: And anything else you can think of that would be a diagnostic tool?

A: Those would be the most common. There are various anti-hypertensive medicines that can be given. The three-phase bone scan and stellate ganglion blocks are the most important.

Q: What would the purpose of an anti-hypertensive medication —

A: You'd have to talk to an anesthesiologist. You're asking me how it responds and I'm not prepared to answer that.

Q: Okay. I appreciate your letting me know that. I think we talked about some of the signs and symptoms of RSD?

A: Okay.

Q: And you had mentioned as part of those signs and symptoms swelling and redness and inflammation, hypersensitivity. Were there any other signs and symptoms that you would look for as —

A: Pain.

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Q: And where would that pain be located, if you were looking for —

A: Usually in the extremity.

Q: Is there ever any changes in muscle mass with RSD?

A: Yes. With lack of use of the extremity you get loss of muscle volume.

Q: Would that be something that would occur over a period of time?

A: Yes.

Q: How long a time would it take for something like that to occur?

A: Depends on how long he's had it and how little use he's had. I mean patients may have 20 percent use of the extremity, 30 percent, 40, 60, 80 percent. If they have limited use or no use you'll see muscle atrophy within weeks. You can see muscle atrophy within three or four weeks if you put your hand in a cast and don't move it and take it out.

Q: Okay.

A: So it all depends upon the degree, use of the extremity. There are bone changes that occur, x-ray changes. They usually take a while to occur, probably three to six months depending

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upon the age of the patient and the severity of the reflux sympathetic dystrophy. The bones get a washed out appearance on x-ray and there are very characteristic x-ray findings as an indication of the late sequelae of reflux sympathetic dystrophy.

Q: Now, by late sequelae, would that — I think you mentioned something about an early stage. Are there stages —

A: The first stage is inflammation.

Q: Okay. How many stages are there?

A: As many as you want, but generally there are considered to be three stages.

Q: Okay.

A: And the first stage is inflammation.

Q: And I think you had indicated that this was a stage that you believed —

A: Right.

Q: — Mr. Dawson to —

A: It's an acute stage and there's a subacute stage where the inflammation begins to subside and you get some loss of muscle mass and you get, you can get some changes in the skin, texture and composition and there's a late stage where the patient has joint stiffness, maybe even ankylosis

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of the joints, meaning inability to move it, severe changes on x-ray with washed out bone appearance, and minimal activity with a inflammation is gone and the hand for example would become firm and hard.

Q: Okay.

A: So those are phases.

Q: What kind of changes would you see on the x-rays between the early phases versus the later ones?

A: Oh, the acute phases x-rays may be normal but late phases x-rays show a loss of calcium in the bone.

Q: Okay.

A: Particularly —

Q: Would that be like an osteoporosis?

A: Exactly. Yes.

Q: Does that occur in all cases with RSD?

A: No.

Q: Is there a way to arrest RSD at a certain age or to reverse it?

A: Is there a cure for it?

Q: I guess that would be one question.

A: Yes, there is a cure. Not all patients are cured.

Q: I know you —

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A: Not 100 percent of the patients who have RSD end up with end stage use of extremities. We have a number of patients who go through an acute stage and then subside, never get into stage two and stage three. Many, many patients like that.

Q: When you say subside, the signs and symptoms?

A: Correct. Resolve.

Q: No longer exist. So it is possible for that to occur?

A: Oh, yes. Once you get to stage three, it cannot generally, from a practical standpoint, be reversed. The sequelae of that cannot be reversed.

Q: What kind of treatment is usually recommended for that first stage?

A: Vigorous hand therapy program with active use of the extremity maintaining active range of motion, medications, and there's a whole list of medications.

Q: Do you know what some of those are?

A: I can send you a list.

Q: Okay.

A: There has to be a hundred different medications.

Q: Now, when you're telling me there's a hundred different medications, how many medications would

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normally be prescribed for a patient?

A: Depends upon the response rate of the patient. Many patients are placed on anything from anti-depressants to anti-epileptics, to anti-inflammatories, to anti-hypertensives, are four categories. And in that category there's got to be eight or ten medications. It is the art of management of reflux sympathetic dystrophy by pain management experts who use a combination of drugs to aid in correction. Some patients respond — let me explain.

Q: Go ahead.

A: I'll put it in a practical term. Migraine headaches.

Q: Okay.

A: There has to be 50 different medications that have been tried. Some work on some people and some don't work on others. You want a list of all the medications in the last 20 years keeping track for migraines. All of them are still current, some are anti-hypertensives, some are anti-depressants. Calcium channel blockers they call them. All of these medications have been used for migraine, and they are still very, very good but not all work on the patient and people

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switch medications until they find something that's helpful. In addition to obvious pain medicine.

Q: And you mentioned four different categories of medication. Is it usually standard treatment to have a medication from each of those four categories as part of the treatment?

A: I don't know. I don't treat this.

Q: Okay. So if you have a patient who comes in with RSD who would you refer that patient to for treatment?

A: Pain management. Someone experienced in pain management. It is generally, I generally refer to an anesthesiologist who has a subspecialty in pain management, because they can do, not only treat the patient with medication, but also do the necessary blocks but pain management also involves psychologists, internists.

Q: Why would a psychologist be involved?

A: There's been many people believe that certain personality profiles exist for patients who get RSD, which is reflux sympathetic dystrophy.

Q: So, in other words, there's certain personalities that would be predisposed toward RSD?

A: Correct.

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Q: And what kind of personalities would those be?
A: I'd have to get the list with this. Again, I'm not an expert on this.
Q: Okay.
A: But there is a personality profile for these, been well-documented. If you want all your answers on RSD you're going to have to get an expert on RSD. I just saw this patient once, and if you want a seminar on RSD we can refer to you the appropriate people who can answer your questions.
Q: Okay. Now, you mentioned therapy also as part of the treatment regimen. Would this be an occupational or physical therapist that would be —
A: Hand therapist. Well, all depends. It's a combination of occupational therapy which does hand therapy and makes splints. And then physical therapy generally does shoulder and larger joints which can be involved. Occupational therapy — hand therapy is part of occupational therapy, and physical therapy is a different discipline and why they're in that category is an historical one.
Q: Are there any other sort of treatments that

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you're aware of for RSD, besides the ones that you've mentioned?
A: Medications, vigorous therapy and blocks are the three major categories. Pharmacological and physical and the blocks. Those would be the three categories.
Q: Have you diagnosed RSD prior to diagnosing Mr. Dawson?
A: Yes.
Q: How many patients do you treat with the diagnosis of RSD?
A: I don't treat RSD.
Q: Okay. So you always refer those patients somewhere?
A: I think there are people better to me.
Q: How many patients have you diagnosed with RSD and referred out?
A: Several hundred.
Q: And you pretty much, with all of them then have referred them to other physicians for treatment.

(Thereupon, a discussion was had off the record.)

Q: When you examined Mr. Dawson did you consider

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some other differential diagnoses besides RSD?
A: No. I thought his, I thought his findings were fairly classic for RSD, based on my physical exam.
Q: So it was the clinical symptoms that —
A: Correct.
Q: — made you come up with that as your diagnosis?
A: Correct.
Q: Okay. And what do you believe caused Mr. Dawson's RSD?
A: I have no idea.
Q: What can cause RSD?
A: Anything.
Q: Such as. Can you give me some examples.
A: Bumping your hand on a cabinet.
Q: So it can be something as simple as that?
A: Innocent. Injuries, acute illness, anything.
Q: And how long does it take for RSD to develop when you have a simple bump?
A: Sometimes several days to several weeks.
Q: Do you know what caused Mr. Dawson's RSD?
A: No.
Q: I believe you documented it as part of your note that Mr. Dawson also had been taking some medication for arthritis, is that correct?

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A: If it's in the records, then it's correct. Yes.
Q: Did he indicate to you where he was having problems with arthritic pain?
A: No.
Q: I believe then you also following your examination and your referral of Mr. Dawson to, I believe, a Dr. Tom Stan, is that correct?
A: Yes.
Q: You also wrote a note then to Dr. Kontak?
A: Correct.
Q: Regarding your examination of Mr. Dawson?
A: Correct.
Q: Have you generally referred your patients to Dr. Stan in the past for treatment?
A: Yes.
Q: And does he traditionally refer back to you then with reports of his treatments?
A: Yes.
Q: Now, I believe that your record does not contain any information from Dr. Stan, is that correct?
A: That's correct.
Q: And what is the reason for him not seeing Mr. Dawson?
A: Insurance. Provider. Dr. Stan was not an accepted provider for his insurance company.

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Q: Do you know who Mr. Dawson was referred to finally?
A: My records indicate he was referred to Dr. Charles Choi at Fairview Hospital.
Q: Okay. And did you ever receive any documentation or reports back from Dr. Choi with regards to Mr. Dawson's treatment?
A: No.
Q: Have you ever received any other calls from Mr. Dawson for follow-up appointments with your office?
A: No.
Q: Okay. And are you aware of Mr. Dawson's current condition at this time, Dr. Cervino?
A: No.
MS. LOESEL: Okay. I'm going to go ahead and let the others ask you some questions while I kind of look through my notes at this point and I may have a couple additional questions once they've had an opportunity to talk with you.

CROSS-EXAMINATION OF A. LAWRENCE CERVINO, M.D.
BY MS. HARRIS:
Q: Doctor, I'm Beverly Harris as I indicated to you

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when we first started. I'm here on behalf of Medina General Hospital.
When you saw Mr. Dawson, as I understand it, he was in first at the early stage of what you believe was RSD, is that correct?
A: Correct.
Q: And in this letter that you wrote to Dr. Kontak, I believe you indicated that three-phase bone scan generally establishes the diagnosis, is that correct?
A: If that's what I said, yes.
Q: Okay. Do you have that in front of you?
A: No. But go ahead.
Q: That's a correct statement?
A: Yes.
Q: Whether or not you said it or not?
A: Right.
Q: Am I correct that now, RSD has been re-labeled, if you will, to be included under the subheading of complex regional pain syndrome?
A: If that's what you want to call it, yes.
Q: Do you go by that categorization or is that something you don't —
A: I don't deal with it.
Q: Under complex regional pain syndrome, do you know

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if this would be, what the RSD would be, Type 1 or Type 2?
A: I don't know.
Q: As I understand it from both your note and your letter to Dr. Kontak, it was your belief when you referred Mr. Dawson that he was in the early phases and should do very well?
A: That's right what I said.
MS. HARRIS: Thank you.

CROSS-EXAMINATION OF A. LAWRENCE CERVINO, M.D.
BY MR. MINGUS:
Q: Dr. Cervino, my name is Ron Mingus. I represent Dr. Kontak and I just have a couple other questions for you.
It was Dr. Kontak who referred Mr. Dawson to you?
A: Correct.
Q: And after you saw Mr. Dawson, you wanted Mr. Dawson to see Dr. Stan?
A: Correct.
Q: And it's your understanding Mr. Dawson didn't see Dr. Stan because his medical insurer denied him coverage for seeing Dr. Stan, correct?
A: Correct.

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MR. MINGUS: That's all I have for you. Thank you.
MR. DOLATOWSKI: Not yet.
MS. LOESEL: You don't have anything?
MR. DOLATOWSKI: Are you going to re-ask anything?

CONTINUED CROSS-EXAMINATION OF A. LAWRENCE CERVINO, M.D.
BY MS. LOESEL:
Q: I think the only other thing I was going to ask you, doctor, is if there are any other diagnoses that would essentially have some of the same symptoms that RSD would have that you're aware of?
A: There are other diagnoses. I didn't consider them at the time because I referred him to Dr. Stan who hopefully would continue with appropriate diagnostic studies. It was my impression he had RSD. I send patients sometimes with regional pain who do not have RSD.
Q: What other kinds of things would they have potentially besides RSD?
A: They could have pain related to cervical

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radiculopathy in the neck, they may have pain of uncertain etiology that is not RSD, but of undetermined cause. One can't see pain.

Q: Okay. What would cervical radiculopathy in the neck be?

A: That would be a disk in the neck.

Q: And would it be a disk that would just have some kind of a calcification around it or impingement or what?

A: It would be impingement. Patients can have impingement in the neck secondary to bone spurs, to a disk, to degenerative changes in the neck, all of which can result in upper extremity pain which some symptoms are suggestive of RSD but it generally doesn't give the acute inflammation that one sees. And this man demonstrated in my mind on a clinical examination the classic signs of reflux sympathetic dystrophy because he had a inflammatory phase.

Q: Okay.

A: And that's with distribution in the little finger side of the hand and hypersensitivity with increased warmth and sweating in the hand. This to me is RSD by clinical exam. If he does not respond appropriately to stellate ganglion blocks

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and infusion of medications, in which one traditionally does, and if he didn't have a positive three-phase bone scan, one would then begin to search for other causes, but I don't treat that kind of problem.

Q: Okay.

A: And there's no question in my mind that some patients I refer for RSD don't have RSD.

Q: Okay.

MS. LOESEL: Okay. Thank you, Dr. Cervino. I appreciate it.

CROSS-EXAMINATION OF A. LAWRENCE CERVINO, M.D.

BY MR. DOLATOWSKI:

Q: Doctor, my name is John Dolatowski. I represent Mr. Dawson. I just got a couple of things.

Your record says I talked to his referring physician, Dr. Jeff Kontak in Wadsworth, and strongly suggested that we expedite arrangements for him to see Dr. Stan for treatment.

You made that clear to Dr. Kontak that this, there was some urgency in him getting some treatment for this, right?

A: Yes. The earlier you treat the patients the better their response. That's well known.

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Q: Do you remember the date that Mr. Dawson was referred to you by Dr. Kontak's office?

A: No.

Q: Did you ever receive any feedback or any response from Dr. Kontak to the letter that you sent him on the same date that you saw Mr. Dawson?

A: No.

Q: And he had told you by the time he saw you on December 20th that he first started experiencing this back when he was in the hospital and that his surgery was on September 1st of 1999, right? That's what your records show?

A: Yes.

Q: So we're talking September, October, November, almost four months after surgery, correct?

A: If that's the dates, yes.

Q: Doctor, do you remember Mr. Dawson testified that you at least expressed to him some disdain, the fact that this hadn't been, nobody had seen this up to this point and you had testified just a little while ago that this appeared to be the classic case of RSD, even without doing the three-phase —

A: Bone scan.

Q: — bone scan and so forth? Do you remember

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having that reaction when —

A: No.

Q: Okay.

A: I can't recall.

Q: Okay. But the redness, inflammation, hypersensitivity, all those were apparent to you upon your examination?

A: Yes.

MR. DOLATOWSKI: Okay. Thank you, doctor.

MS. LOESEL: I have no further questions.

MR. MINGUS: I have a couple, doctor.

CONTINUED CROSS-EXAMINATION OF A. LAWRENCE CERVINO, M.D.

BY MR. MINGUS:

Q: Although you didn't have any personal contact with Dr. Kontak after the patient left your care, the notes below your note indicate that your office and Dr. Kontak's office did have contact on December 29, 1999 about referring this patient to an anesthesiologist, correct?

A: Correct.

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Q: And it was at that time there was discussion that the appointment that had been arranged for Dr. Stan would not be able to take place because the medical insurer had denied coverage, correct?
A: Correct.
Q: And the very next day after that an appointment was made for the patient to see Dr. Choi, correct?
A: If that's what Dr. Kontak's office said, yes. I didn't make the appointment for Dr. Choi.
Q: Okay. You had made the appointment for Dr. Stan?
A: Correct.
Q: Okay. And the appointment you had made for Dr. Stan, that was for some reason set aside because the medical insurer didn't provide coverage?
A: Correct.
Q: Okay. And then subsequent arrangements were made for this patient to see Dr. Choi, correct?
A: Correct.
MR. MINGUS: That's all I have for you. Thank you.
THE WITNESS: Thank you.
MS. LOESEL: Dr. Cervino, I probably should advise you, generally when a deposition is taken the party who's been

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deposed has the right to read the deposition or can waive the reading of that deposition.
THE WITNESS: I would prefer to waive.
MS. LOESEL: Thank you.

(The reading and signing of the deposition was expressly waived by the witness and by stipulation of counsel.)

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CERTIFICATE

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

I, Aneta I. Fine, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named witness was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action; that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this _____ day of _____ A.D. 20 . .

Aneta I. Fine, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires March 1, 2006

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