THE STATE OF OHIO,)
) SS:
COUNTY OF CUYAHOGA.)

FEB 16 11:00 AM

IN THE COURT OF COMMON PLEAS

JEFFREY L. DZIGIEL, et al.,)
)
Plaintiffs,)
)
) Case No. 125340
v.)
)
WILLIAM BRUCK, M.D., et al.,)
)
Defendants.)

Doe 119

- - -

Deposition of ROBERT CURTIS CORN, M.D., taken by the Plaintiffs as if upon cross-examination before Lisa Hrovat, a Notary Public within and for the state of Ohio, at the offices of Robert Curtis Corn, M.D., 850 Brainard Road, Highland Heights, Ohio, on Monday, the 18th day of January, 1988, commencing at 5:00 p.m., by agreement of counsel.

- - -

APPEXRANCES:

Joseph L. Coticchia, Esq.,

On behalf of the Plaintiffs.

Jacobson, Maynard, Tuschman & Kalur Co., L.P.A., by:
Thomas H. Terry III, Esq.
and
Robert C. Maynard, Esq.,

On behalf of Defendants Dr. Bruck and Dr. Kovaeh.

Arter & Hadden by:
Victoria L. Vance, Esq.,

On behalf of Defendant St. Luke's Hospital.

STIPULATIONS

It is stipulated by and between counsel for the respective parties that this deposition may be taken in stenotypy by Lisa Hrovat and that her stenotype notes may be subsequently transcribed in the absence of the witness.

ROBERT C. CORN, M.D.,

called by the Plaintiffs for the purpose of cross-exanination, as provided by the Ohio Rules of Civil procedure, being by me first duly sworn, as hereinafter certified, deposes and says as follows:

CROSS-EXAMINATION

BY MR. COTICCHIA:

Q. Dr. Corn, will you please state your full name?

A. Robert Curtis Corn.

Q. What is your business address?

A. 850 Brainard Road in Highland Heights, Ohio.

MR. TERRY: Can we go on the record for just a moment? I just want to show that Steve Albert who represents Marymount Hospital was notified of the fact this deposition was going forward at 5:00. It is now 5:20 on the 18th and no one has appeared, and we have decided to go forward.

This is a deposition being taken by agreement and it is being taken pursuant to Rule 26-B of the Ohio Rules of Civil Procedure. Is that a fair statement?

MR. COTICCHIA: Yes.

Q. (BY MR. COTICCHIA) What is your residential address, Doctor?

A. I live in Cuyahoga County.

Q. What is your address, your home address?

A. River Road in Gates Mills, Ohio.

Q. The number?

A. There is no street number.

Q. Are you a specialist in medicine?

A. Yes.

Q. What is your specialty?

A. Orthopedic surgery.

Q. Are you board certified?

A. Yes.

Q. When were you board certified?

A. 1980.

Q. When did you obtain your license to practice law in Ohio?

MR. TERRY: Medicine.

Q. (BY MR. COTICCHIA) I mean medicine.

A. I didn't realize I had a law degree.

Q. Do you have a resume or curriculum vitae? 1976.

A. I don't have one right with me.

Q. Rather than go into that right now, would you mail a copy to me or send it to your attorney and he will mail it to me?

A. I can give you one at the conclusion of the deposition.

Q. Thank you. Do you spend 75 percent of your professional time in the clinical practice of medicine?

A. I spend probably 90 percent of my time in the clinical practice of medicine.

Q. Today prior to this deposition, what records, or reports, or letters, hospital records, whatever, did you review in regard to the treatment of Jeffrey Dzigiel?

A. I reviewed records from St. Luke's Hospital, records that were provided from the Industrial Commission of Ohio, records from Marymount Hospital and ... interoperative pictures that were taken during the first.. open operation as well as a copy of the Plaintiff's expert report, Dr. Wise or Weiss, from Columbus.

that you are referring to in the interoperative report?

A. I believe these are from the first open operation, the arthrotomy, which is 1-8-85.

Q. Did you, along with reviewing the medical. records, consult or review any medical textbooks in the area of orthopedics?

A. I did not review any particular textbooks, no.

Orthopedic infections is one of my areas of interest, and I have a pretty good working knowledge of the old literature as well as the current. I didn't feel it was necessary to review any of the major textbooks.

Q. What textbooks do You have here in your office?

MR. TERRY: Objection.

A. I have a recent copy of Campbell's on orthopedics, I have an old copy of Campbell's. I have a lot of them. Do you want me to list all of them?

Q. (BY MR. COTICCHIA) A few of them. Do you consider Campbell's on Orthopedics an authoritative source?

A. I think it is an authoritative source. It comes from one particular clinic that has a somewhat conservative background, but it is a good text for orthopedic surgery. It is not the Bible, but it is a good textbook. I have a copy of Turek, T-u-r-e-k, principals in Orthopedics. There are probably 40 other books listed, I am not really sure. If you have any specific ones you would like me to review, I would be happy to tell you if I have them,

Q. What medical journals or publications do you subscribe to?

A. I subscribe to the Journal of Bone and Joint Surgery, both British and American, to Clinical Orthopedics and Related Research, to the Orthopedic Clinics of North America, the Orthopedic Audio Synopsis Tapes, which are monthly CME, continuous medical education, as well as a variety of instructional course

lectures published by the American Academy of Orthopedic surgery as well as the Yearbook of Orthopedics published by Yearbook Publishing Company.

Q. I didn't get the very first one you mentioned,

A. The Journal of Bone and Joint Surgery, both American and British.

Q. Have you written any articles which have been published pertaining to any field in orthopedics?

A. Yes.

Q. What were the topics; and when were they published?

MR. TERRY: I thought we agreed the doctor would send me a copy of his curriculum vitae and you can have all of that stuff, Joe. I am sure it is listed in there.

A. I don't remember the exact dates.

Q. Are they listed in your resume?

A. They are listed in my curriculum vitae, yes.

Q. Do they deal with infections?

A. A number of them deal with orthopedic infections, including some major talks that I have given, including the talks to the Cleveland Orthopedic Society.

Q. All right. Do you know the Defendant, Dr. Bruck?

A. No.

Q. Have you talked to Dr. Bruck at any time since the inception of this case?

A. I don't know Dr. Bruck.

Q. You don't know him at all?

A. I don't know him at all.

Q. Do you know the defendant, Dr. Kovach?

A. I know of Dr. Kovach. I don't know him personally, though.

Q. Have you talked to him over the phone or through correspondence since the inception of this case?

A. Absolutely not.

Q. Do you receive your professional liability insurance from Physician's Insurance Exchange?

MR. TERRY: Objection. Instruct you not to answer.

A. Yes, I do.

MR. COTICCHIA: He has already answered.

MR. TERRY: I am sorry. Move to strike.

Q. (BY MR. COTICCHIA) Have you ever been on any review committees or review panels for Physician's Insurance Exchange?

MR. TERRY: Objection. Direct you not to answer. I would indicate for the record that I am not Dr. Corn's personal attorney, and actually I can't direct him not to answer anything. I am recommending that he

not answer these because the questions are outside the scope of Rule 26-B which is the limited rule authorizing this deposition.

As Mr. Coticchia is well aware, he has the right to determine what the doctor's opinions are and the basis of those opinions. The questions that he is seeking answers to at this time are found to be irrelevant and inadmissable.

There is a Court of Appeals' decision out of the 8th District Court of Appeals that holds that to be a fact. And I would appreciate it if Mr. Coticchia moved on and completed the deposition as permitted by rule.

Q. Doctor, are you going to answer that last question?

A. I have been directed not to. If you want me to, and if the other attorneys --

Q. I want you to. He is not your attorney.

MR. COTICCHIA: In response, id you want to go into a legal argument, I have a right to ask that question. You don't have a right to tell the witness not to answer the question,

MR. TERRY: Sure I do.

MR. COTICCHIA: It is relevant because your expert is insured by the same company the defendants

ants

are.

MR. TERRY: That, too, is irrelevant. The case law clearly holds that it is irrelevant, Mr. coticchia. If you want to get into the 26-B(4) decision, fine: otherwise, as far as I am concerned, I can pack everything up and call it a day. I may end up paying money, but we will not go forward until it is resolved by the Judge. That is quite simply --

MR. COTICCHIA: The case of Ralston Purina Company versus McFarland, 550 F 2d 967 (1977) holds that you may not instruct the witness not to answer a question, particularly an expert witness for the defense. It is obviously important or you would not have told him not to answer.

MR. TERRY: That is a great way to figure it out.

MR. COTICCHIA: It is relevant because the expert is insured by the same company as the Defendants, so it is obviously relevant or will lead to relevant information.

MR. TERRY: That is the most ridiculous position that I have heard asserted yet.

MR. COTICCHPA: I agree with you, Mr. Terry, we will let the Court decide that. I found this Court is a little more sensible on some of your arguments,

MR. TERRY: Fine with me.

Q. (BY MR. COTICCHIA) I would like to get some terms defined, Doctor, before we get into the discussion of the treatment.

Does septic mean bacteria or infection in the blood?

A. I am sorry?

Q. Does the word septic, s-e-p-t-i-e, mean bacteria or infection in the blood?

A. It can mean that. Septic usually is an adjective. It is not a noun. It can be septic areas, sepsis.

Q. Sepsis.

A. Sepsis can be a blood borne or widespread infection.

Q. What does articular surface mean?

A. Articular surface is the surface of two adjacent bones that join forming a joint. It is usually made up of cartilage, and surrounded by a joint capsule and synovium or lining of the joints.

Q. What is cartilage?

A. Cartilage is a compound that is a very complex protein polysaccharide, that is a very complex sugar and protein combination of amino acids and sugars which has a very high water content, and because of its high water

question. And I think penicillin, again, in appropriate dosages, can be given in a hip joint infection but I don't think this man had a hip joint infection.

Q. On the second page of your report, Doctor, you state that there were some intra-articular fragments that were preventing complete relocation of the hip. You go on to state "unusual osteochondral fracture with multiple loose pieces in the joint."

Dr. Corn, isn't this substantial bony destruction of Jeffrey Dzigiel's joint surface?

A. No, there wasn't substantial destruction. There are inoperative pictures that show this is a small portion of the femoral head, but there is damage of floating pieces. If this was due to an infection, the whole femoral head would have been involved and not a small section of the femoral head.

Q. What are these pieces evidencing?

A. A fracture, an injury, a traumatic incident.

Q. This is not, in your opinion, an indication of a joint infection?

A. In this case, after looking at the pictures, no, it is not indicative of a joint infection.

Q. Wouldn't the infection first affect the cartilage before it affected the bony structure of the femoral head?

content and chemical composition, makes it very slippery, It is basically a complex that allows for tremendous loads, both weight-bearing and muscle, to pull without any destruction to itself.

Q. Is the cartilage usually found over the joint surface?

A. A type of cartilage or hyaline cartilage is a type of cartilage that is found in adjoining areas that make up the joints. There are elastic cartilage, fibro cartilage and several other things, but I am assuming *you* are limiting the discussion to hyaline.

Q. What is the acetabulum?

MR. TERRY: I am going to object. If he wants a definition of these things, he should buy a dictionary. He is, under Rule 26-B, not to get an education, but find out the opinions and the basis of the opinion. Steadrnan's Medical Dictionary provides answers to each and every one of the questions so far.

Q. (BY MR. COTICCHIA) What is the acetabulum, Doctor?

A. The acetabulum is the pelvic components of the hip joint.

Q. Is that what we as laymen refer to as the socket of the hip?

A. It can be called what is referred to as the

socket of the hip.

Q. What is the femur?

A. It is the thigh bone, the largest bone in the human body.

Q. Calling your attention to a model of a bone in the pelvic area, do you recognize that model?

A. Yes.

Q. Does it reasonably depict the hip joint and femur as well as the acetabulum?

A. Yes.

Q. What is the femoral head?

A. The femoral head is the upper end of the thigh bone or femur that is the ball part of the ball and socket joints which composes the hip.

Q. What is osteomyelitis?

A. Osteomyelitis is defined as a chronic inflammatory condition of bone as the etiology of microorganism or a group of microorganisms.

Q. What is a girdlestone surgical procedure?

A. A girdlestone surgical procedure is -- classically it is a procedure wherein a portion of the neck and femur are removed as well as the supra and supralateral aspect of the acetabulum are excised.

Q. What is subluxation of the hip or hip joints?

MR. TERRY: Objection.

A. Subluxation is defined as a partial slippage or eccentric arrangement between the ball and the socket part of the hip joint.

Q. What is a staph infection?

MR. TERRY: Objection.

A. A staph infection is an infection with the etiology or the organism cultured as a staph'species.

Q. Do you have a copy of your letter to Mr. Terry dated August 13, 1987?

A. Yes.

Q. Is it your opinion that-a staphylococcus aureus infection of the hip would destroy the hip in a three- to five-day period?

A. A staph infection of the hip joint or any joint will destroy the articular cartilage within three to five days, yes.

Q. Articular cartilage?

A. Yes.

Q. We are not referring to the bone itself?

A. No.

Q. Don't indolent or low-grade infection or a common variety -- let me repeat this.

Do you agree that there are many bacteria that don't necessarily follow a destructive or fulminant course?

MR. TERRY: Objection. I am not sure what you mean by fulminant course.

Q. Rapid or wide spread.

A. There are certain bacterial infections which are of the lower virulence and lower grade, but these are usually skin contaminants and are very rarely associated with a septic joint without direct inocculation with the needle or some other procedure.

Q. There are low-grade infections, aren't there, that are common with a variety of bacteria?

MR. TERRY: Objection. That calls for speculation on the part of the witness.

MS. VANCE: It is impossible to answer, medically.

A. I don't know how to answer your question. I really don't.

Q. You were discussing in your report that Dr. Bruck had ordered penicillin.

Can the course of a low-grade infection be masked by the use of penicillin?

A. The course of a low-grade infection could be masked by massive doses of penicillin uses parentally, intramuscularly or intraveneously. I have never seen penicillin in and of itself slow down a significant infection, at least not in this day and age.

Q. And this was an ongoing thing, wasn't it?

MR. TERRY: Objection.

A. The fever --

Q. (BY MR. COTICCHIA) What was it?

A. He had a low-grade fever. I am not sure it was 102 the whole time, but was 102 during the day.

Q. In your opinion, during this approximate month of treatment, you didn't think it was necessary for Dr. Bruck to order a blood culture?

A. I don't think it was clear from review of the medical records that this man was having shaking chills or having spikes of temperature elevation during this month period of time.

From what I understand, and also reading through the notes, there was nothing that would suggest doing any kind of blood cultures. I certainly wouldn't order blood cultures on an outpatient. If I thought he was serious enough, I would have brought him in the hospital and done blood cultures. It was mainly complaints of pain and not complaints of fever and pain, and night sweats, and things that would indicate a systemic infection.

Q. On September 30, 1985 Dr. Bruck's notes show that Jeffrey Dzigiel had a temperature of 102.

MR. TERRY: Is that a question?

muscle rupture which would certainly account for the problems in the early stages of the atelectasis and prior to the first arthrotomy procedure.

Q. Do you agree that Dr. Bruck should have obtained periodic blood cultures to determine the presence of infection in Jeffrey Dzigiel's blood?

A. I don't believe that blood cultures are without severe spikes and temperature elevations and fevers and chills because it is probably going to be a normal and extensive blood test to run, and you don't' find out about it for 24 to 48 hours.

Q. How long did Jeffrey's treatment with Dr. Bruck last?

A. I don't remember. At least a couple weeks. I can't remember the exact dates, from September 23rd until --

Q. October 29th?

A. October 14th is the first time he saw Dr. Kovach, so it was about a month, a little less than a month.

Q. If I am not mistaken, don't Dr. Bruck's notes or office charts state that he had a temperature of a 102 degrees?

A. I think in one of the notes it did say that, yes.

MR. COTICCHIA: I don't know. It is what the doctor has put in his report.

MR. TERRY: Why don't you refer to it?

Q. What time period were you referring to?

A. Tell me in the report where I said that. I don't remember where it is. Okay. It is at the top of Page 3.

Q. Right at the beginning of Page 3, right.

A. One of the most common reasons is a mild atelectasis for any obese person who would remain sedentary for long periods of time. It is probably one of the most common causes of low-grade fever. This may not be visible on a chest X-ray.

Q. Is it your opinion, based on reasonable medical certainty, that Jeffrey Dzigiel's elevated temperature was caused by atelectasis due to his obesity?

A. One of my differential diagnoses would be that. I don't know that that would be my only diagnosis. That is certainly one of the diagnoses I would entertain if this was my patient.

Q. Well, now that you Rave gone through all of his treatment records, what do you attribute the fever to?

A. I am not sure where his fever was coming from. I would be willing to bet it came from his lungs, or from the blood clot, or the hematoma that formed from the

Q. Should Dr. Kovach have specifically ordered tissue stains to determine the presence of bacteria or microorganisms?

A. No.

Q. Is it something the hospital should do?

A. I am sure the hospital did it. Pathologists cannot make a diagnosis without stains. You cannot even see anything on the slides without stains. He makes an excellent tissues diagnosis which is compatible with the entire clinical picture. Just because he doesn't mention stains doesn't mean they were not done. There is no specific need for specific stains to rule out infection. The typical garden variety of stains used in all preparation of pathological specimens would have picked up microorganisms, or at least an increase in white blood cells, and it says nothing of that sort.

Q. You go on to discuss and wonder what the cause of the temperature was that Jeffrey Dzigiel was running.

Is it your opinion, based on reasonable medical certainty, that Jeffrey Dzigiel's elevated temperature was due to atelectasis caused by his obesity?

MR. TERRY: Objection. I want you to figure out in your question, Mr. Coticchia, what time period you are talking about. Immediately after the injury? After the initial procedure? When?

A. The hemotoxin, which is used in staining all tissue, would pick up infection.

Q. (BY MR. COTICCHIA) There is nothing in the path report mentioned.?

A. They usually don't have to mention it because it is the major stain they use. You can't see the cells until you stain them. They look like little clear areas of tissue. And the stain -- You have to remember when the tissue is removed they, just don't stick it under a microscope.. They first have to remove the water-content and then they have to remove that and replace it with alcohol and replace it with a xylene, which is another type of chemical, and cut in very, very thin sections and put it on a slide. And if you held up that slide befor-e staining, it would have like a smudge, a fingerprint-. It is a typical stain they use, which is the H and E stain, that would easily pick up a microorganism.

Q. You would say, on a presumption, that that was done by the people in the path lab?

A. Yes, I am assuming it was done in the path lab.

Q. My question is, there is nothing stated in that report about this test being done?

A. I don't know. No, there is nothing exactly about what was done, no.

months, I would expect probably a good four or five shot glasses full of pus or some infected looking material, and there was none described.

Q. Assuming that he has got this penicillin, wouldn't it be normal to find a lot of cloudy fluid rather than pus under these circumstances?

A. I don't know how anybody could say that.

Q. Now, you mentioned there was nothing stated in the path report.

Can a pathologist determine the presence of infection if he hasn't specifically stained the tissue specimen from the joint surface for microorganisms?

MR. TERRY: Objection.

A. Most pathologists, it would be negligence on their part to fail to make a diagnosis on the tissues obtained. The tissue does not need any special stain for infection unless it was tuberculosis which, obviously, this gentleman did not have. In general, most pathologists would stain and look for something. I am sure they were suspicious. And most doctors, when they do a procedure, will discuss the case with a pathologist where a pathologist is usually aware.

Q. Would you agree a stain is necessary to look for microorganisms in case of an infection of the hip?

MR. TERRY: Objection.

tissue fragments with areas of hemmorhage and repair tissue from right hip joint.

Q. could that also be in reference to the cartilage?

A. It says bony and fibrous tissue. Cartilage can look like fibrous tissue when it is ground up and involved with hemorrhagenic process of injury; although it doesn't say much about cartilage here. There was basically something that looked like a blood clot and something that looked like bloody bone. This was called a cartilaginous fracture.

Q. You go on to mention there was no pus found in the area of the hip joint.

If there was an infection, wouldn't that hip joint infection be modified by the use of antibiotics so that there would not be the presence of pus?

A. Well, what I mean by that statement that there was no pus in the joint, it is clear that in the path report there was no obvious sign of infection, there was no signs of infectious organisms in the soft tissue that was studied, and there was no evidence of an infection on the pathology specimen. The fracture could have an infection without pus, of course. But usually when there is a significant amount of fluid in the so-called septum joint that has been there allegedly for almost two

that time that Dr. Kovach elected to go in with the arthrotomy and the exploration after an attempted closed reduction that didn't work.

Q. The arthrotomy did not disclose a fracture, did it?

A. I believe it did. It showed loose pieces in the joints, and it showed there was loss of articular cartilage in certain areas of the loose pieces that were in the joint.

Q. There was no fracture found in the acetabulum, correct?

A. Yes, that's correct.

Q. And the loose pieces?

A. Were from the femoral head.

Q. Are they cartilage or actually bony structure?

A. I believe they were cartilage that was torn away from the bone so there may have been one with it. I don't really recall. I would have to look at the path report. You would probably find it a little bit easier to find than I would. I have to go through all of these records to find where the slip is.

Q. I am going to give you my copy. Is there anything in that path report that describes the tissue as bony structure from the femoral head?

A. It says bony fibrous tissue and granulation

for weeks just from bleeding into muscles, bleeding into the deep tissues.

Q That is after surgery?

A. You can see it prior to trauma after surgery. It depends on the amount of bleeding in the tissue.

Q. In this case Jeffrey Dzigiel did not sustain any trauma: by that I mean a blow to his hip, did he?

A. From what my understanding is, it was initially felt there was a muscle rupture, and later it was felt that it was a somewhat unusual fracture in which part of the articular surface separated from the femoral head. From what I understand of the injury, there was no direct blow, such as a fall, or being struck by a car, or something like that. It was an unusual body positioning.

Q. Don't the x-rays, until the open reduction, fail to show the clear fracture in the joint surface of Jeffrey Dzigiel?

A. I believe the first x-ray didn't show anything abnormal other than the subluxation with the CAT scan that was performed. But the x-rays, if one goes through them, were very difficult to interpret because of the patient's size. The quality of the x-rays did not allow one to visualize the deep structures, but the CAT scan did show there were fragments of the joint, and it was at

A. We are dealing with a time period, the time of injury, which is September 23, 1985, to the arthrotomy which was performed on 11-5-85. That is almost two months. I would say the infection would be highly unlikely, as there would have been a great deal more soft tissue and bony involvement, and there was none.

In my opinion, this again was from increased amount of fluid, which was causing the subluxation as well as the fractures. There was never a culture taken, nor any other evidence of a septic infection or osteomyelitis in any of the records. So I think this man, in my opinion, did not have an infection.

Q. You are aware that throughout the course of this treatment, going back as early as Dr. Bruck's charts, Jeffrey Dzigiel had a low-grade temperature?

A. Low-grade temperature, yes, but that is a very, very common -- in my mind, it is not a significant problem.

Q. It is a symptom of low-grade infection?

A. A temperature elevation is a symptom of a low-grade infection or can be a symptom of a low-grade infection. It can also be normal for some people, and it can also be indicative of a severe inflammatory process or bleeding into a tissue. It is not unusual after fractures or major surgery for people to run fevers

Q. you mentioned that penicillin was not your drug of choice. What would You have recommended rather than penicillin if you were in Dr. Bruck's position?

MR. TERRY: Objection.

A. If you are asking me if I had a choice of another antibiotic, would I use another one, and my answer would be yes, and I would use a cephalosporin antibiotic.

Q. Is that why Dr. Bruck should not have used penicillin?

A. I didn't say he shouldn't have used penicillin. I said I would have used a different medication.

Q. What kind of bacteria or infection was Dr. Bruck trying to fight when he ordered this penicillin?

A. I have no idea.

Q. There is nothing in the record to indicate that, is there?

A. No. It could have been anything from a sore throat to pneumonia.

Q. Does penicillin work to fight a hip infection?

MR. TERRY: Objection.

A. I have never seen a hip infection in an adult. I don't think they are very common when young -- this is a septic hip problem. You are asking me a theoretical

MR. COTICCHIA: No. It is just to clarify the record.

MR. TERRY: I move to strike that. If I want to take your deposition, I will do it.

MR. COTICCHIA: Lots of luck, Terry.

Q. If the fever, despite the penicillin, persisted, is it still your opinion that Dr. Bruck should not have ordered blood cultures?

MR. TERRY: Objection. I don't think that question is relevant,

A. I don't think I can answer that. It is a hypothetical situation. I don't know. I don't have an opinion.

Q. Is it your opinion that Jeffrey Dzigiel had an intra-articular fracture of the hip?

A. Yes.

Q. Exactly where was the hip fracture, if you can show us on the model?

A. Well, unfortunately, the model -- I would have to take it apart.

Q. You may certainly do that.

A. It is difficult to say on the pictures exactly what portion of the femoral head was involved, but it was clearly around the weight-bearing surface somewhere around the superior aspect of the ball.

Q. For the record, you are pointing to the top?

A. Essentially, somewhere in the weight-bearing surface, yes.

Q. What do you base that opinion on?

A. The operative description and interoperative photographs.

Q. Is it your opinion that the fracture not only included cartilage, but also the bony structure of the femoral head?

A. There was bony involvement of the femoral head. I am not sure how significant a piece of the femoral head was damaged. That was not clear by the photographs, the x-rays or by the operative note.

Q. Was there any fracture within the acetabulum?

A. There was none noticed.

Q. Is it your opinion that the fracture at the surface of the hip joint caused an increase in the joint fluid?

A. Absolutely, yes.

Q. Is it your opinion that the increase in the joint fluid caused Jeffrey Dzigiel's subluxation of the hip?

A. Yes.

Q. And as you said, is subluxation a moving away from the center of the head and socket?

A. I don't believe those are my words, but essentially.

Q. In substance?

A. In essence, yes. In other words, the hip will not center itself, will not come into its normal location due to hydrostatic pressure pushing it apart.

Q. Do you agree that intra-articular fractures alone will not cause a low-grade temperature? When I speak of intra-articular fractures, I am speaking of --

A. Just the physical presence?

Q. Yes.

A. No, not the physical presence, but the body's reaction to them may. In other words, there would be increased circulation, there would be a tremendous increase in inflammatory response, a tremendous change in the circulatory response, and this could cause a mild temperature elevation.

Q. Isn't it well established that an intra-articular joint infection causes an increase in fluid accumulation?

A. There are certain hip joint infections which can increase the hydrostatic pressure, yes: some, not all.

Q. Can we agree that the arthrotomy done by Dr. Kovach on Jeffrey Dzigiel disclosed joint damage?

consisting of right hip joint infection?

MR. TERRY: Objection.

A. No, I don't believe so.

Q. (BY MR. COTICCHIA) We have established or you have agreed that a hip infection can cause an increase in fluid within the hip joint?

A. In the pediatric age group, in the childhood age group.

Q. An increase in the fluid can cause subluxation of the hip joint?

A. Yes.

Q. Mr. Dzigiel had an increase in the hip joint fluid, did he not?

A. I don't know. I was not there at the time of surgery. That is one of the theories that I am working on.

Q. There is something to that effect in Dr. Kovach's records, aren't there?

A. Yes.

Q. All right. We know at some point he had an infection, didn't he?

A. No, we don't know that at all. There was never any documented positive culture other than drainage positive culture.

Q. From the wound site?

A. Yes, I think we can establish that.

Q. If the intra-articular fractures of the bone are present, doesn't this indicate damage to the articular surface of the femoral head?

A. Yes.

Q. Do you agree that a persistent temperature is a cause of infection?

MR. TERRY: Objection. Asked and answered.

A. I do not think that one can automatically assume that any rise in temperature, either for a long or short term of time, is solely due to infection, No, I disagree with that.

Q. (BY MR. COTICCHIA) Do you agree without a blood culture that shows no bacterial growth you cannot rule out the diagnosis of hip infection?

A. Hip joint infection has absolutely nothing to do with what is circulating around the blood. You can have a whopping hip infection, as is very commonly seen in children and not seen in adults, and have a normal blood culture and no organisms in the blood culture. Blood culture, all it establishes is there were organisms in the blood stream and not anywhere else.

You see the abscesses in the abdomen, abscesses in knee joints as well as other areas, brain abscesses. You don't have to have a positive blood

culture.

Q. So in theory, we can agree that Jeffrey Dzigiel could have a sub-acute joint infection and yet a negative blood count?

MR. TERRY: Objection.

A. I am not stating that. He did not have a sub-acute joint infection.

Q. I am speaking theoretically.

A. I don't like to speak theoretically. Is there a question?.

Q. You just stated, didn't you, a person can have a perfect hip and the blood culture come-back negative?

A. It is unusual, but it is possible.

Q. Do you agree that Jeffrey Dzigiel's medical records disclose a lengthy progressive and painful clinical course?

A. Absolutely.

Q. Do you agree that x-ray findings disclose subluxation of the right hip?

MR. TERRY: Objection. Which ones?

Q. (BY MR. COTICCHIA) Whatever x-rays you referred to in your report.

A. There are x-rays that were taken which do reveal there is subluxation of the hip joint.

Q. Aren't these also symptoms or findings

A. From the drain site. Not the wound site, the drain site. And on the final definitive pathological report at St. Luke's of the femoral head, there was no evidence of osteomyelitis.

I would clearly think any orthopedic surgeon, if there was a hip joint infection that was there for two months, there would be bony changes compatible with osteomyelitis, and there were none. There is no documented evidence of a hip joint infection in any of the medical records. This is clearly supposition.

Q. Without going through all of the x-rays and medical records, do you recall reports of a significant demineralization?

A. Yes.

Q. What is that?

A. A demineralization is basically what we call bone atrophy. It is loss of calcium in the bone. It is seen extremely commonly in people that are bedridden, people that are not ambulatory, people that are casted and immobilized for a long time. It is not an unusual finding.

Q. It is not caused by infection?

A. It is not always caused by infection.

Q. Can it be?

A. Can it be caused by infection? Yes, it can be.

Q. Isn't that another symptom of a hip infection?

MR. TERRY: Objection.

A. No, it is not a symptom of a hip infection. That is a symptom of osteomyelitis of the bonem not a joint infection. It has nothing to do with the joint. The bone has nothing to do with the joint. A hip joint infection or any joint infection is within the joint. It has nothing to do with the surrounding bone.

And there was no evidence on microscoping of the femoral head there'was ever any osteomyelitis. The form on the addendum on the bottom of the St. Luke's pathological report showed no evidence of osteomyelitis present. Osteomyelitis can cause demineralization of bone. -Septic arthritis doesn't commonly cause demineralization of bone.

Q. Is it your opinion, based on these records that you have reviewed from Marymount and St. Luke's, there was no osteomyelitis of the femoral head?

A. There was no biological or pathological presence of osteomyelitis. The pathologist clearly stated on the review of the bony specimen there was no sign of osteomyelitis.

Q. Is that the path report?

A. That is the Marymount path report. The final path report from St. Luke's Hospital I am referring to.

Q. Can you find in your record when this would be?

A. There are no positive cultures from the hip joint, there were no positive cultures from the bone, and in a minute I will find the pathology report for you.

MR. TERRY: Wait until there is a question, Doctor. I think he has something specific in mind.

Q. You are referring to St. Luke's, is that correct?

A. That is the only time they ever -- they remove any bone other than the bone chips that were removed at the time of the first open operation. You probably have it somewhere in yours.

Q. I want to back up.

Calling your attention to what is dated November 16, 1985, this is the Marymount record.

This is a routine culture for the wound. For the record, it states "stain result, few WBC, some gram positive cocci, heavy staphylococcus aureus, rare enterococcus."

MR. TERRY: Objection. Move to have that marked and attached to the deposition, Your reading of the thing is slightly deficient.

Q. (BY MR. COTICCHIA) Do you remember seeing that

when you reviewed the records?

A. Yes.

Q. Does that not show --

A. It says right hip drain site.

Q. -- an infection?

A. Hip drain site. It says, "wound (and specify)" and I specifically specify this is the right hip drain site. This is not the incision. This is where the drain comes out of the site. And it says, heavy rare enterococcus. Few WBCs." This is not a wound infection. This is a drainage culture.

Q. The drainage is coming from where? --

A. We don't know where the drainage is coming from. It could be coming from the deep tissue. In other words, a swab is taken right around this area, and you have no idea how it is taken, maybe a skin contaminant. Nobody really knows.

Q. Could it be coming from the hip?

A. I don't think it is coming from the hip.

Q. Is it possible?

A. To a reasonable degree of medical certainty, no, in my opinion.

Q. We can at least agree there is a blood culture Positive for infection, can't we?

A. It is not a blood culture. This is a drain

site culture. This is not a wound culture. This is a hole that it is coming from, and there is persistent serus drainage that somebody stuck a swab in and got a culture from.

Q. Is this not checked off routine culture?

A. All hospitals ask you to specify that, "(specify,) right hip drain site." That is what that means today.

We agree --

A. That has nothing to do with the wound.

Q. So in your opinion, based on all the records of Jeffrey Dzigiel's treatment, he did not sustain osteomyelitis of the femoral head?

A. There is no osteomyelitis of the femoral head, that's correct.

Q. No evidence in the records that you have reviewed?

A. That's correct.

Q. Do you agree in theory if a sub-acute infection of the hip is not diagnosed and properly treated, it can cause osteomyelitis of the femoral head?

MR. TERRY: Objection.

A. I think, in general, an unchecked infection of a joint can do one of three things: It can spread into the blood, it can spread into the nearby soft tissue, or

spread to adjacent bone. So I guess Your answer could be yes, although it is not definitively yes.

Q. Do you agree that the surgery of the femoral bone and hip socket is proper treatment for Osteomyelitis of the femoral head?

A. I am not sure that I understand your question. Are you talking about the girdlestone procedure?

Q. Let's say this is due to an infection rather than trauma, fracture. Would the girdlestone procedure be the right treatment?

A. Absolutely. There is no doubt in my mind that Dr. Kovach, by the time Jeffrey was in the St. Luke's Hospital, felt this was osteomyelitis of the bone. And I think that he probably discussed this with his orthopedic colleagues, and I believe he did the girdlestone as a first of a two-stage procedure in which to do a hip replacement on this guy.

This is a typical type of thing. You get the infection out, you treat him agressively with antibiotics, and you go back in at a later time and do a hip replacement no matter how young or how fat they are. That is a whole separate issue. It is a typical type of thing. But the actual pathological report was that there was no osteomyelitis.

I think they were working a presumptive

diagnosis that it was infected after the arthrotomy in a post-op infection and not an infection that Stemmed from a septic, from a hematogeneous spread or blood-borne spread. I think that is the appropriate thing to do. It looked like it was infected, but by the time he got to St. Luke's he was on a broad number of antibiotics and they had a positive culture from a blood slide. It was -- assuming it was coming from the hip joint itself, that would have been the most severe sequela of post-op, and they -- I believe they 'treated him adequately on that.

My personal feeling, although it is not in the records because he never -- Jeffrey never came back to Dr. Kovach, was that it was the first stage of a two-part procedure in which the potential infection was excised in an attempt to go back at a later time to do a definitive reconstruction operation. This is a typical state-of-the-art approach for infections of the hip joint.

I believe if it was infectious, there was never anything that said this joint was infected. If it was infected, and if there was osteomyelitis, it occurred after the arthrotomy, it occurred after the open operation, it did not preexist the first open operation. It was the complication of a post-op wound operation. In fat people, it is unfortunately very, very common. Nobody really knows, because there really is no evidence,

there has never been a culture from the joint itself, a swab stuck directly in the hip joint or evidence in the pathological evaluation of the bone that there was osteomyelitis or joint infection present. It was assumed, because of his clinical course and the way the hip joints appeared to be deteriorating, but there was no osteomyelitis. And I am sure it was surprising -- it was surprising to note that, and I did not denote that on my first report.

Q. Should a culture have been done?

A. A culture should have been done, but this guy was on big-time antibiotics. They were trying to kill anything they could kill. Enterococcus, which is the cultural organism, if it wasn't there would be. No, he would be dead. If it was an enterococcus, he would have been dead in a week if it was not treated. So I wouldn't expect anything to be cultured. He was just bombarded from his arriving at St. Luke's Hospital. If I can recall, he was on at least four or five antibiotics at that time, all of them with major side effects in an attempt to handle a post-op wound infection or post-op infections.

Possibly because of the massive doses of intraveneous antibiotics, there was also no evidence of osteomyelitis on the pathological review. The

antibiotics would not have killed the microorganisms in the bone. They could have killed the microorganisms in the soft tissues, but there would have been microorganisms in the bone and there were none. It is very peculiar, a real diagnostic dilemma from day one, and a real challenge to all doctors involved.

Q. I don't know if I asked you this, but I am going to ask you again. Do you agree if a sub-acute infection of the hip is diagnosed during the early stages, osteomyelitis of the femoral head can be prevented?

A. I don't think you asked the question quite that way. I think early detection and early treatment could prevent osteomyelitis, yes, in general.

Q. And, of course, if it is detected and prevented, then the surgical sectioning and surgery of the hip and the acetabulum is not necessary?

A. I don't understand what you mean by sectioning. What was sectioned?

Q. I am talking about the girdlestone.

A. Resectioned when it was removed?

Q. Yes. If you get to it soon enough, you don't have to do it?

MR. TERRY: Objection to the form of the question.

A. That is not necessarily true. In some infections, some types of infections, you want to remove it. You want to remove it as part of a two-stage procedure. You want to try to cure the infection, and it does, and one of the treatments of infection is adjointive abscess and removal of infected tissue.

I think they went in the second time at St. Luke's with an assumption that he was infected, which is why they went ahead and did the girdlestone procedure. But no culture and nothing throughout of the bone or soft tissue. It was probably due to the massive doses of antibiotics, and there was massive doses that he was getting.

Q. At the end of your report you say that in all likelihood the diagnosis of this was somewhat clouded by the patient's large size and the inability to obtain appropriate x-rays or aspirations. Are you referring to Jeffrey Dzigiel's obesity?

A. Yes.

Q. Does Jeffrey Dzigiel have a right to receive the same standard of care and treatment as other patients have a right to receive regardless of his obesity?

A. I think he did. He had exactly the same things that they would do for anybody, but it is technically more difficult to interpret an X-ray when you

are shooting through six inches of soft tissue than shooting through three inches of soft tissue.

Q Do you agree that Jeffrey Dzigiel now has a permanent injury in his right hip?

A. Absolutely, but it is reversible and able to be improved to a great extent by the second stage.

Q. Is there anything in the records that you reviewed that would disclose or indicate this second stage was planned by Dr. Kovach?

A. No, but then again there was never any real follow-up from his discharge from Highland View.

Q. Let's go back toward the beginning of your report. I want to ask you, you state that Jeffrey Dzigiel was not septic, and we know that Dr. Bruck never ordered a blood culture. What do you base that opinion on? What basis?

A. People who are septic, there is no question they are acutely ill. Nausea, vomiting, sky-high fever, sweats, shaking, chills; these are the common signs of sepsis, very high temperature elevations, 102, 103, 104, persistent spiking with a very malignant type of clinical course. He could not have survived if he was septic at that time.

Q. Didn't we just agree that according to Dr. Bruck's chart Jeffrey Dzigiel had a temperature of 102

degrees?

A. At one particular time he did. Yes, he did. There is no evidence at all there was a sustaining temperature or he was suffering from shaking, chills.

Q. Is severe pain in the right thigh and hip area a symptom of hip infection?

MR. TERRY: Objection.

A. Is it a symptom? I think people that have hip joint infections may have severe pain but it is seen in many, many other things: acute arthritis, chronic arthritis, muscle tear, muscle rupture, inguinal hernias. It is a very common symptom and also, certainly, with fractures of the femur.

Q. Were you able to find anything in Dr. Bruck's record of Jeffrey Dzigiel that he physically examined Jeffrey Dzigiel?

A. I don't know. I can't remember.

Q. Now, we talked about the x-ray report or you mentioned the early x-ray report which is September 30, 1985. Did you ever actually see the x-ray film?

A. I saw a bunch of films. I can't remember exactly if I saw that particular one.

Q. This would be the one that Dr. Bruck ordered?

A. I don't remember.

Q. What do you mean medically when you take a history of a patient?

MR. TERRY: Objection.

try to find out the who, what, where and when of why they are there, you try to elicit as many facts about them: in other words, these are subjective things. You are asking the patient to recall certain events that happened historically.

Q. A history is important when a doctor is trying to make a diagnosis, isn't it?

A. A history is important, but it also is dependent upon the patient's ability to describe what happened and what went on, and that sometimes is cloudy. But, obviously, a history is an important aspect in making a diagnosis.

Q. Isn't it a fact there is no history in Dr. Bruck's records?

MR. TERRY: Objection. There is clearly a history in the emergency room records. I am not sure it is necessary to repeat -- doctors are not permitted to review, nor are the lawyers, to review the charts later. And some doctors are somewhat more cryptic and may not need to write down everything but

can write down much about the original illness, and I don't think that is a criticism.

Q. (BY MR. COTICCHIA) Have you ever reviewed any medical records regarding treatment on behalf of a doctor who is a defendant in a claim for medical malpractice?

A. Yes.

Q. Independent of this case?

A. Yes, I have.

Q. Do you remember the names of the cases?

MR. TERRY: Objection.

A. I don't know the names.

MR. TERRY: That is outside the scope of this hearing.

A. I can easily obtain them for you.

Q. How many cases have you reviewed specifically of medical malpractice?

A. I have reviewed approximately 14 cases, maybe 15 cases in total. Half of them were plaintiff-oriented.

Well, I reviewed far more potential medical negligence cases where plaintiff attorneys came to me to review the records and I would determine whether there may be medical negligence present for them to pursue if they chose to.

I reviewed probably 150 over th past few

years. But the ones I have been specifically involved with have been seven as a defense expert and three or four as a direct plaintiff's treating physician, and then the others were basically I saw the patient but did not choose to get involved with a negligence case.

Q. Have you ever written an opinion or given a deposition as an expert witness on behalf of a patient on a malpractice suit against a doctor?

A. Yes, I have.

Q. On how many occasions?.

A. On one case, and it was against my insurance company.

Q. Mr. Terry is from the firm of Maynard, Jacobson --

MR. TERRY: Jacobson, Maynard, Tuschman & Kalur.

MR. COTTICHIA: I thought it was Jacobson, Maynard, Tuschman & Kalur.

MR. TERRY: It still is until you changed the name.

Q. Do you know how Mr. Terry got your name --

MR. TERRY: Objection.

A. No, I really don't.

Q. -- as a defense expert? Do you know any other attorneys from that office?

A. A number of attorneys are my patients.

Q. From Mr. Terry's firm?

A. Yes.

Q. Do you know Mr. Maynard?

A. I know who he is. I don't know him personally.

Q. Do you know Mr. Jacobson?

MR. TERRY: Objection. This is ridiculous.

A. This is ridiculous.

Q. Do you know --

MR. TERRY: This is well outside the scope of discovery. Mr. Coticchia, you know what 26-B is. Limit yourself to it. I know it is tough, but try.

A. I don't know any principals of the law firm personally. I could recognize them in a crowd, but not to go up to talk to them.

Q. Do you know Mr. Kalur?

MR. TERRY: He already answered the question. Quit harassing him.

A. I could recognize him, but I don't know him at all to talk to him.

Q. Have you ever written reports or opinions regarding medical malpractice for any of the partners?

MR. TERRY: Objection.

A. of the principal Partners? No.

Q. Have you ever done any review or given opinions in regard to standard of care for William Bonezzi?

A. Yes.

Q. When was that?

MR. TERRY: Objection.

A. Well, actually, it was -- actually I haven't testified to anything yet. I had written one letter which was last week that I signed today, as a matter of fact.

Q. Do you know the name of that case?

MR. TERRY: Objection.

A. Yes.

Q. What is the name of that case?

MR. TERRY: It is outside discovery. Find out yourself.

A. You are putting me in a difficult position.

MR. TERRY: I instruct you not to answer.

MR. COTTICHIA: He can note his objection. The Court can determine whether or not it is relevant evidence.

MR. TERRY: It is not relevant to what

the scope of the deposition is. You have been practicing for a nurber of years. You know the scope. Limit yourself to it. Otherwise, I will shut it down and we will go and find out. You have the medical opinions, you have the basis for them. Why don't you confine yourself to proper questioning?

Q. Do you remember the question?

A. Yes, I do.

Q. Do you remember the case in which you are acting as an expert?

A. I remember the doctor's name, but not the plaintiff's name.

Q. What was the doctor's name?

MS. VANCE: Let me interject for the doctor here. I don't think it is appropriate for him to be put in the position of answering your questions. It really calls for a legal opinion. You are asking him really as an expert, and he may not understand that in relationship to the particular case, plus it may be divulging a confidence of the attorney involved in the case and his work product, and I don't think this witness should be put in that position.

MR. COTICCHIA: I am not asking him to disclose his work product. I am asking him the names and attorneys he has written reports to.

MR. TERRY: You don't know whether they have been disclosed or not. You know full well discovery only goes to his experts who are going to be used. You don't know whether Bonezzi's report is going to be used or not. Fine. He wrote a report for Bonezzi. Move on, Mr. Coticchia.

Q. Have you ever written a report for Dale Kwarciany?

A. Yes.

Q. When?

A. During 1977. I don't remember the dates.

Q. Mr. Kwarciany is also --

MR. TERRY: I will stipulate that Mr. Kwarciany is a member of the firm of Jacobson --

Q. You know that is a medical malpractice case?

A. Yes.

Q. Has suit been filed?

A. Suit has been settled or determined. It is closed.

Q. Did that involve standards of care of orthopedic treatment?

A. Yes.

Q. Do you remember the name of the case?

A. No.

Q Do you remember the case of the doctor?

A No.

Q Have you ever written opinions and reviewed records for Morris Kirshman?

MR TERRY: Objection This is harassment.

A. Yes.

Q (BY MR COTICCHIA) When did you do that?

A I don't remember. 86 or '87 I don't recall the exact dates

Q Was it again on behalf of a doctor?

A I assume so. But I really don't remember the particulars of the case.

Q Have you ever reviewed any records or written opinion for Cyril McIlhargie who, for the record, is no longer with the firm?

A I believe at one time I may have reviewed records, but I don't recall

Q You don t remember when it was?

A I have no idea

Q Was this on behalf of a doctor who was the subject of a medical malpractice claim?

MR MERRY: If you recall, Doctor.

A I really don't remember

Q Have now ever reviewed any records or

written an opinion for Susan Reinker?

MR. TERRY: Objection. Move to strike.

A. Have I ever reviewed any records or written an opinion? I don't remember. I have known Susan for a number of years. I may have, but I really don't remember.

Q. Have you written any reports or reviewed any records for Stephen Charms?

A. Stephen Charms is a patient of mine, so I sort of stay away in getting involved for him, but I did get involved in one a number of years ago.

MR. TERRY: Move to strike.

A. I think in '83 or '84 I may have reviewed something for him.

Q. Was that on behalf of the doctor or the patient?

A. I don't remember. I don't remember the details.

Q. Do you know John Jackson?

A. No.

Q. Have you ever reviewed any records or --

MR. TERRY: Objection. How could he?

A. I don't know the name.

MR. TERRY: How could you possibly expect an intelligent answer if he doesn't know him?

Q. Have you written an opinion or reviewed any records at the request of Andrew Buckner?

A. Andrew Buckner? I don't remember the name,

Q. Have you reviewed any records or written a report at the request of Patrick Murphy?

A. I don't remember.

Q. Have you reviewed any records or written a report at the request of Steven Albert?

A. I don't recall.

Q. Independent of this case, have you reviewed any records or written any reports for Mr. Terry?

A. I think I did one, but I don't remember who that was about or what that was about. It was a couple years ago.

Q. So this would be the second time that you have written an opinion as an expert at the request of Mr. Terry?

A. I think so. I really don't remember.

Q. Do you remember the name of that case?

A. No. I am not even sure I did. I think I did, but I don't remember.

Q. In regard to medical malpractice cases, how do you have given?

MR. TERRY: Objection.

A. Three or four, I think.

A. Three or four, I think.

Q. Have you ever given any depositions as a medical Expert on behalf of the plaintiff?

MS. VANCE: I think we have gone through this.

A. *Yes.*

MR. TERRY: Several times.

MR. COTICCHIA: He said he has--been an expert, and I said about depositions.

MS. VANCE: I think he answered that question.

Yes, there was deposition involvi that lawsuit.

of August 13, 1987, do you have any other opinions or are you aware of any other facts pertaining to Jeffrey

today or that may not be in your report?

A. The only aspect that is not in my report was after re-review of the medical records was, in fact, there was no evidence of osteomyelitis in the femoral head that was obtained at the time of the girdlestone procedure. It would make me think there still was a presumptive diagnosis of a hip joint infection, but there was never any definitive objective evidence that there was, in fact, an infection in his

hip. That is the only way my report would have changed.

Q. If between now and the time of trial when you testify as the expert for the Defendant, if you have an additional opinion as to what you mentioned now in the path report from St. Luke's, will you please inform Mr. Terry so that he informs me of any additional opinions or facts that we have not' discussed here in your deposition?

I would be glad to.

MR. COTICCHIA: Can we agree to that,

MR. TERRY: I know what my duties are

MR. COTICCHIA: I am not so sure.

MR. TERRY: That is okay. Don't worry

MR. COTICCHIA: Okay. I don't have any

MS. VANCE: No questions on behalf of

MR. TERRY: Thank you, Doctor. You understand you have the right to review the deposition and sign it, or you can waive signature. I would suggest

MR. COTICCHIA: I don't have any

preference. I am going to order a copy promptly and you may read it and sign anything you want.

THE WITNESS: I think I would like to review it.

(Deposition concluded 6:40 p.m.)

I have read the foregoing transcript from page 1 to page 58 and note the following corrections:

PAGE:	LINE:	CORRECTION:	REASON:

ROBERT C. CORN, M.D.

Subscribed and sworn to before me this day of , 1988.

Notary Public

My Commission Expires:

THE STATE OF OHIO,)
) SS: CERTIFICATE
COUNTY OF CUYAHOGA.)

I, Lisa Hrovat, a Notary Public within and for the state of Ohio, duly commissioned and qualified, do hereby certify that ROBERT C. CORN, M.D. was by me, before the giving of his 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 subsequently transcribed into typewriting by means of computer-aided transcription under my direction; that said deposition was taken at the time and place aforesaid by agreement of counsel; and that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I hereunto set my hand and seal of office at Cleveland, Ohio, this 8th day of February, 1988.

Lisa Hrovat

Lisa Hrovat, Notary Public
Within and for the State of Ohio
540 Terminal Tower
Cleveland, Ohio 44113

My Commission Expires: January 15, 1992.