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Gastrointestinal Surgery

Advanced Laparoscopic Surgery

Bariatric Surgery

January 6, 2003

Re: Royanne Amidi

Dear Ms. Kolis:

I am writing to confirm my review of the above patient's medical records including records from MetroHealth, Cleveland Clinic, Dr. Nicholas Ksenich, Elyria Hospital, and St. John Westshore Hospital. In brief summary, the patient was a 29 year old female with massive obesity (BMI 90 Kg/M^2) who underwent roux-en-y gastric bypass by Dr. William Fallon for treatment of her obesity on March 22, 2002. She died on March 26, 2002.

The patient developed significant postoperative tachycardia followed by progressive sepsis and septic shock. Ultimately, Dr. Fallon opened her abdominal incision and found dirty brown fluid within. The patient died of progressive sepsis and resultant cardiopulmonary collapse.

My opinion is that this patient suffered from an intra-abdominal source of sepsis which led to her demise. It is statistically most likely that the source of infection was an gastrojejunal or jejunojejunostomy anastomotic leak which led to severe intra-abdominal infection. Although no autopsy was performed to confirm this, I believe the above sequence of events is more likely than not.

In my opinion, Dr. Fallon's management of this patient fell below an acceptable standard of care for a general surgeon practicing bariatric surgery by failing to evaluate and treat this patient for intra-abdominal sepsis. Her death was caused by this failure.

Please contact me if I can provide additional information to you.

Sincerely,

Eric J. DeMaria, MD

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December 12, 2003

Ms. Donna Taylor-Kolis
Friedman, Domiano & Smith Co., LPA
1370 Ontario Street
Sixth Floor, Standard Bldg.
Cleveland, Ohio 44113-1704

RE: Royanne Amidi

Dear Ms. Taylor-Kolis:

I have received and reviewed the deposition of Dr. Fallon. I am writing to affirm that my opinions about management previously stated in a letter dated January 6, 2003 have not changed based upon this review. I remain convinced that Dr. Fallon's management of this patient was below the appropriate standard of care for bariatric surgical management. Specific concerns include that he was unaware the patient had recent diagnosis of cellulitis and recent treatment with antibiotics in addition to my previous concerns that he clearly never suspected or investigated the possibility of intra-abdominal anastomotic leak with peritonitis. Specifically, he states repeatedly that he was not concerned about this possibility because of the patient developing early signs of infection in the early post-operative period. GI perforation and leak are known to occur commonly in the first three to four days after gastric bypass surgery.

Please do not hesitate to contact me if you require additional input in this case.

Sincerely yours,

Eric J. DeMaria, M.D.