IN THE COURT OF COMMON PLEAS

OF CUYAHOGA COUNTY, OHIO

Doc. 145

LESLIE M. LYNIX, et al.,

Plaintiffs,

vs. Case No.

PARMA COMMUNITY 85610

GENERAL HOSPITAL, et al.,

Defendants.

- - - - -

Deposition of KENNETH DVORAK, M.D., a Defendant herein, called by the Plaintiffs for examination under the statute, taken before me, Vivian L. Gordon, a Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at the offices of Harry E. Guion, Esq., 5566 Pearl Road, Parma, Ohio, on Monday, July 14, 1986, at 10:00 o'clock a.m.

- - - - -

PG LN ----------COMPUTER INDEX----------

PG LN -----THIS-INDEX-IS RESEARCHED BY-COMPUTER-----

APPEARANCES:

On behalf of the Plaintiffs:

HARRY E. GUION, ESQ.

JONATHAN GATZ, ESQ.

5566 Pearl Road

Parma, Ohio 44129

886-7089

On behalf of the Defendant

Parma Community General Hospital:

Weston, Hurd, Fallon,

Paisley & Howley, by

JOHN W. JEFFERS, ESQ.

25th Floor Terminal Tower

Cleveland, Ohio 44113

241-6602

On behalf of the Defendant

Kenneth Dvorak, M.D.:

Reminger & Reminger, by

STEPHEN D. WALTERS, ESQ.

The 113 Building

Cleveland, Ohio 44114-1273

687-1311

On behalf of the Defendant
Charles Greenwald, M.D., Greenwald,
Hanna & Schoeck, Miguel A. Dominguez,
M.D., and Albainy Pathology Assoc., Inc.:
Jacobson, Maynard,
Tuschman & Kalur, by
STEPHEN CHARMS, ESQ.
One Erieview Plaza
Cleveland, Ohio 44115
621-5400

ALSO PRESENT:

Leslie M. Lynix
Edwin J. Wagner, Esq.

MR. GUION: Doctor, I'm going to be asking you a lot of questions. Obviously I am going to go through a lot of records.

I'm not in any sense or way trying to fool or confuse you. If I ask you anything that you do not understand or you have any doubts about what I am asking, ask me and I will clarify it.

I will assume if you do answer the question that you do understand it; is that reasonable?

THE WITNESS: Yes.

Q. To begin, would you state your full name.

A. Kenneth James Dvorak.

Q. Your residence address?

A. 5711 Warwick Road, Parma, 29.

Q. Doctor, your date of birth?

A. 9/6/49.

Q. Doctor, what I would like to do first of all is go back and get your educational background so we have a basis for things.

Will you tell us where you went to high school?

A. Padua.

Q. That's in Parma?
A. Yes.
Q. What year did you graduate from Padua?
A. 67.
Q. Would you take me from there where you went to college?
A. Western Reserve and I graduated four years later.
Q. That would be 1971?
A. That's right. Yes. I did a year research after that at Milwaukee County Hospital.
Q. What did that involve?
A. Cancer research.
Q. Okay.

MR. JEFFERS: Where was that?

THE WITNESS: Milwaukee, Marquette.

A. I was a special Fellow in the department of surgery at that time.
Q. This was prior to going to medical school?
A. Yes.
Q. Did your year at that institution involve any of the facial type tumors that we will be getting into discussing later today?

A. No.

Q. What type of cancer was it?

A. Lung cancer.

Q. Okay. Go ahead.

A. Then I came back to Western Reserve and went to their medical school. I graduated in 1976.

Following that, I did a year of internship in general surgery at the Cleveland Clinic and I followed that by a year of general surgery residency at the Cleveland Clinic.

I followed that with three years of ear, nose and throat at University Hospitals of Cleveland.

I followed that with an Allen Scholarship for 12 months in a combined program with University and Cleveland Clinic.

Most of my time was at the Cleveland Clinic.

MR. JEFFERS: Allen?

THE WITNESS: A L L E N.

A. I followed that by acting six months as a chief resident in the plastic surgery program at which time my financial situation was such that I quit and went into practice.

Q. What year was it that you went into practice?

A. I always have trouble remembering. I think 1983.

Q. 1983?

A. Yes.

Q. That was the year then that this case transpired that we are talking about?

A. Yes.

Q. That was the year you started your private practice?

A. Yes.

Q. Going back to medical school, what year did you graduate in general? I am trying to remember. You started medical school --

A. 72 to 76 were the years I was in medical school.

Q. Now, during that time in medical school, did you become familiar in any way with the disorder or disease process that we are talking about here today, which is basically this juvenile nasopharyngeal angiofibroma?

A. Yes.

Q. You had some exposure to that in medical school.

In what form did you have exposure to that disease process?

A. Textbook exposure.

Q. Do you recall that textbook you used at that time? What would the textbook be?

A. Numerous. Ballinger and Saunders were the two that we relied on.

Q. Ballinger and Saunders. Both books were on otolaryngology?

A. Sort of bibles, that sort of thing.

Q. Also a textbook like Murphy, a bound white five volume type, did you use?

A. Yes. That textbook is made up of contributions by numerous authors. Murphy actually didn't write that book.

Q. Is that an authoritative text in the field of otolaryngology, along with others?

A. I'd say it is used not anywhere near the bible.

Q. But a textbook recognized as a standard for ENT men?

MR. JEFFERS: What is the other one?

THE WITNESS: Ballinger.

MR. JEFFERS: And what was

the other one?

THE WITNESS: A textbook by Saunders. And also a different one by Papparella, P A P P A --

Q. Are these all textbooks that are considered authoritative?

A. Yes.

Q. Now, following medical school, you did what after medical school?

A. A year of internship.

Q. During that year of internship, did you have any further exposure to this type of tumor, this angiofibroma?

A. No.

Q. You ran into no case of that type?

A. Right.

Q. And after that year of internship, you did what again?

A. A year of residency in general surgery.

Q. During that time did you have any exposure to any of these?

A. No.

Q. Following that --

MR. JEFFERS: The answer was no?

THE WITNESS: The answer was no.

Q. Following that?

A. During my residency in ear, nose and throat I did have exposure.

Q. There you did. Was there additional textbooks or those same three?

A. I remember clinical cases, a couple of clinical cases.

Q. Of what had been diagnosed as the juvenile nasopharyngeal angiofibroma?

A. Yes.

Q. I will call it JNA for understanding.

A. Sure.

Q. Your residency then was at the Cleveland Clinic?

A. No. Ear, nose and throat residency was at University.

Q. Who were the doctors in ENT that were on the staff?

A. Katz, Witt, Slyman, Sogg, Sedwick Quick was there for a short period of time and that's it.

Q. These were the men that trained you during residency?

A. Yes.

Q. Then following the residency, what was your next step?

A. Allen Scholarship.

Q. What did that involve, exactly? Where did you --

A. Teaching ear, nose and throat and doing research on skin transplantation.

Q. Where did this take place?

A. Both at University and at the Cleveland Clinic.

Q. So you were involved in teaching.

Now, in the course of that teaching, did that involve some of these types of tumors? Did you have occasion to get into this at all in teaching?

A. No. In that year there were no JNA.

Q. What did you do next after that?

A. I entered the plastic surgery program at University Hospitals.

Q. Now, do you know what year that was?

A. I suspect it was started in July of 82.

Q. Who were your teachers at that point?

A. John Dupre was chairman of the department, Gary Brownstein was there. Linda Chuck was

there, and those are the three I remember.

MR. JEFFERS: Is that the John Dupre from Harvard?

THE WITNESS: Yes.

Q. Then in 1983 sometime you went into private practice?

A. Right. January of 83.

Q. To continue your education beyond that, what did you do? Did you take any formal training programs? Did you attend any seminars or lectures?

What did you do from January of 1983, let's say, through December of 83 to continue your education?

A. I attended the yearly meeting of the head and neck, ear, nose and throat meetings.

Q. What is the name of that society? Does it have a name, that society?

A. I guess it is the American Society for Head and Neck Surgery, Otolaryngology, Facial Plastic and Reconstructive Surgery.

Q. Were those meetings held in different cities every year, the same way the law things are?

A. Uh-huh.

Q. In addition to that, did you continue your education through reading the journals written by experts in the various journals?

A. Uh-huh.

Q. What journals do you subscribe to?

A. The Journal of Head and Neck Surgery, the Journal of Otolaryngology.

Q. Any others that you subscribe to?

A. Also Laryngoscope.

Q. Any others?

A. I read the Plastic Surgery Journal, Plastic and Reconstructive Surgery.

Q. Those are all authoritative journals that give you information that you can use in your practice?

A. Yes.

Q. In addition to that, do you read any journals peripheral to your direct practice; Radiology, Cancer, those type of journals not directly related to ENT journals, but which may on occasion have issues or articles?

A. Uh-huh. I would like to point out that I have published 30 papers, so I'm quite familiar with journals and reading them, out of interest.

Q. What are some of the journals that you

have published articles in?

A. New England Journal of Medicine, Transplantation. I think I have an article in Cancer. And a number of other articles. I just don't recall what they are.

MR. JEFFERS: Did you bring a CV with these publications?

THE WITNESS: I didn't, but I can get you one.

MR. GUION: I would like that, Steve, if you can get that to me.

Q. In your practice then in January, we now move to this specific case in point.

I would like to take you through some of the items and events that occurred.

First of all, we are talking about obviously Little John Lynix.

By the way, refer to your records when I ask you any questions about any of this, doctor.

Along those lines, let me make sure of one thing. This was sent to me by request of a motion to produce all of your office records and so forth. I see you have an enormous stack there.

MR. WALTERS: These are not

his office records. You said he had an enormous stack.

MR. GUION: I didn't finish, Steve.

Q. Included in that enormous stack, I assume, are your office records?

MR. WALTERS: Let's get the record straight. He has a black binder from my office which are Cleveland Clinic and Parma records.

MR. GUION: Okay.

MR. WALTERS: That's the enormous stack. This very thin packet is his office records, okay?

MR. JEFFERS: Doctor, could you just show me the face sheet on what he handed you?

MR. GUION: Okay. These are his office records.

Q. These are your office records; is that right, doctor? I'm not trying to -- I'm looking at what is in front of me.

A. Uh-huh.

Q. Let's see what you have. I just want to see if we have everything that's the same,

that's all. I don't want to start asking you about things I don't have.

MR. JEFFERS: Is that what is on the cover?

THE WITNESS: I believe so. A couple of clinical notes.

MR. JEFFERS: I'm with you. If I were looking like this?

THE WITNESS: Yes.

Q. In other words, doctor, is it fair to say that what I am looking at right now, here in my hand right now, these are your entire office notes, everything in your possession, other than the hospital records? Everything in your possession is in this folder handed to me by your attorney; is that correct?

A. That's correct.

Q. What I want to do is just go over those.

You have a statement in there, a bill that is from 11/22 to 6/15. That's one page.

We can go through these one by one.

It looks to me like they are identical. I just want to identify them, that's all.

MR. WALTERS: I will fold those up.

Q. You have a statement there, number 2. That's one page. You have office notes on a patient which are two pages. I saw them somewhere.

A. Three pages.

Q. Let me see if I understand that.

MR. JEFFERS: Does it actually cover four sides?

THE WITNESS: Yes.

MR. WALTERS: You have been provided Xerox copies of that folder that has those office notes on it.

MR. GUION: I see. I didn't understand that this was part of the ENT.

Q. The ENT and office notes are really four pages, okay.

I understand that now. The Parma Hospital admission summary of 1/27/84, which is one page.

MR. JEFFERS: The discharge summary now?

MR. GUION: No, the admission summary, one page, 1/27/84 is the date. Also there is the Parma --

THE WITNESS: I don't think

I have that in my office chart. That would be in the hospital chart.

MR. JEFFERS: I have your discharge summary report.

MR. GUION: I am going by what was sent to me by your attorney.

MR. WALTERS: No. I think there is a history and physical report.

MR. GUION: Parma Hospital admission summary dated 1/27. Here. This looks like -- this was what was sent to me. Let me see if I can find it.

MR. WALTERS: Find it in the copy.

MR. GUION: I have it numbered five, history and physical, right here.

MR. WALTERS: That's not the admission summary.

MR. GUION: Well, it is called --

MR. JEFFERS: History and physical. We do not have anything in our Parma Hospital called admission summary.

MR. GUION: Back here, up here is admission summary, number 3.

THE WITNESS: I think the terminology, it is a history and physical.

MR. WALTERS: This little half sheet. It is there.

MR. JEFFERS: That's the face sheet.

Q. Now, we have those five. The next one is a middle ear analyzer 1723 form dated 1/5/84.

MR. WALTERS: Yes.

Q. The next is Parma Hospital urinalysis. There is an addendum to that, okay.

That is called the middle ear analyzer.

MR. GUION: That may have been on here. That's right here, okay.

MR. WALTERS: Part of the same Xerox sheet.

MR. GUION: Right.

Q. There is an urinalysis dated 11/26/83, Parma Hospital.

MR. WALTERS: Here it is. What is the date?

MR. GUION: 11/26/83.

MR. WALTERS: What I am doing, Harry, as you read these off, we are putting them back in back to front, or do you

want it from front to back?

MR. GUION: It doesn't matter.

MR. WALTERS: I want to do it the way you want.

Q. The next one is Parma Hospital operative report 11/26/83.

MR. JEFFERS: Which is the date?

MR. GUION: 11/26/83.

MR. WALTERS: Here it is.

Q. The next one is the operative report -- I mean the Parma Hospital CAT scan 1/27/84.

A. I have it.

Q. The next is the Armed Forces Institute of Pathology report of 1/30/84.

MR. WALTERS: Yes.

Q. Doctor King, Ram and Associates radiology report of 12/16/83.

A. There it is.

MR. WALTERS: We have it.

Q. The Clinic notes from 2/27/84 to 7/25/84 consisting of three pages.

MR. JEFFERS: I have four.

MR. GUION: You may have

something later than what he has in his records. I think I have some more too.

MR. WALTERS: Wait. He has a couple laying over here. There we go.

MR. GUION: The four is one, the duplicative of the other. The one is the same as the other.

MR. WALTERS: One had been sent to him before the subsequent visit.

MR. GUION: So there are four pages?

MR. WALTERS: Four pages.

MR. JEFFERS: From where, Harry, February 27th through?

MR. GUION: July 25, 84.

MR. WALTERS: Whether or not everything is on these, I don't know. For example, one sheet has a note of Dr. Levine of February 27, 84, nothing below it. The next sheet has a copy of that same note, but by this time there is a March visit noted below. The next one has just a May 2, 84 of Levine and the fourth one has just the July 25 of 84 of Levine.

Since these are simply copies of Cleveland Clinic records, whether or not there

are additional entries there, I have no idea.

MR. GUION: That's no problem.

Q. And the last thing is the Parma Hospital discharge summary of 1/27/84 which consists of two pages.

Now, what is left that I don't have on this list?

MR. JEFFERS: One page or two pages on the discharge summary?

THE WITNESS: Two.

Q. Whatever is left, I don't have.

A. History and physical.

Q. History and physical for -- no, that's okay. I have a copy of it anyway. History and physical of 1/27, okay.

MR. WALTERS: What about this CBC card?

MR. GUION: What was that?

MR. WALTERS: 1/26/83. I think they were on one sheet.

Q. This constitutes, doctor, your entire office file that you had from the time you first saw this patient until the last time you saw the patient?

A. Yes.

Q. Okay. What I would like to do next is -- we will start on the records that we just went over and talk about those visits.

Your very first visit with the patient was on what date?

A. The 22nd.

Q. By the way, before you refer to those, doctor, do you have an independent recollection of young John? Do you remember him at all?

A. Uh-huh.

Q. What do you remember about him in terms of the significant medical factors, without referring to the records?

MR. JEFFERS: For the entire time?

Q. From the first visit on?

A. I remember John had been sick a long time and had been seen by a number of physicians before he had seen me, and he was referred to me after quite awhile. Somebody happened to look in his nose and saw what appeared to be a foreign body and said, help us out, there is something in here. We have been seeing him a long time and we are worried that maybe

something needs to be done.

I saw John and looked at his X-rays which the previous physician had obtained, and looked in his nose and saw a foreign matter in there. I thought it was a foreign body that he had placed in it.

I scheduled him for surgery. Surgery was done, I believe, the next day or next few days. At that time it was not a foreign body, it was a neoplasm. The etiology was not determined at that time.

A subsequent determination came back to be a benign neoplasm.

He had significant bleeding at the time of surgery. Confirmation came back at that time that this was a benign problem we are dealing with. I thought that we had extirpated it totally at the time and followed him along; however, his clinical course was up and down. It improved one time and it would be worse the next time.

As time went on, we got more studies and at the last time I saw him, we admitted him to the hospital to get a consult, surgical consult and CAT scan, and it turned out that the CAT

scan revealed a new finding in terms of the extent of more, and we transferred him to the Cleveland Clinic.

Q. Okay. Let's start with that very first visit, 11/22.

Now, you can refer to your notes. You said he had been seen by a lot of other doctors. Who had he been seen by?

A. Pediatrics Services Incorporated and Dr. Mohan Durve.

Q. The Pediatrics Services, was there a particular person that he had been seen by?

A. I don't have that.

Q. If I was to tell you that was Dr. Hostetler --

MR. WALTERS: What is the name?

Q. Did you at any time, doctor, have any contact whatsoever with Dr. Hostetler?

A. No.

Q. Were you aware that he was in fact the pediatrician that was involved in taking care of Little John?

A. I assumed it was Dr. Butler, because she helped us when John had bleeding after surgery.

Q. Is she associated with Dr. Hostetler?
A. Yes.
Q. In the same office?
A. Yes.
Q. You had no contact with Dr. Hostetler?
A. That's correct.
Q. Did you at any time receive any records from Dr. Hostetler's office or his forms from any physicians?
A. No.
Q. Now, the next doctor was which one?
A. Mohan Durve, D U R V E.
Q. What was your contact with Dr. Durve?
A. Dr. Durve got an X-ray and said this child has a real severe sinus infection. I have been treating him for allergies and he hasn't gotten better. He happened to get an X-ray to see what we can find and you look at the child for me.
Q. Did he send you any of his office records or his office notes?
A. No.
Q. Did he tell you how long he had been treating Little John, how many times he had seen him prior to referring him to you?

A. He had mentioned it in passing; numerous times.

Q. He said he had seen him numerous times?

A. He had done a number of allergy tests. He had done blood tests and scratch tests.

Q. What did he say about those tests?

A. Those are negative.

Q. He had an X-ray taken at the time?

A. No. He had an X-ray taken subsequent down the road.

Q. But prior to seeing --

A. Prior to seeing me, he did have an X-ray.

MR. JEFFERS: He did not?

THE WITNESS: He did.

Q. Had he interpreted that X-ray for you?

A. Yes.

Q. What was his finding?

A. One sided sinus infection.

Q. Did you have an occasion to review that same X-ray?

A. Yes, I did.

Q. What were your findings?

A. Opacification of the right maxillary sinus consistent with an infection.

Q. Was that patient referred to you by Dr.

Durve?

A. Yes.

Q. That's how you came to see Little John is Dr. Durve specifically sent him to you?

A. Yes.

Q. During the course of your treatment from 11/22 to the termination on 1/27, did you ever go back to Dr. Durve and tell him the progress of the case or have any oral consultations with him?

A. Probably four times.

Q. What were the -- tell me the gist of those consultations or conversations.

A. I found something in John's nose that is causing his infection. It could be a foreign body or neoplasm. Whatever it is, it should be removed. We will do it under general anesthesia.

I let him know how John did under general anesthesia and kept him informed twice during his post surgical care.

Dr. Durve had, in fact, records that I sent him.

Q. What is his specialty?

A. Pediatric allergy.

Q. Does he have any control over the type of tumor that we are talking about, the juvenile nasopharyngeal angiofibroma? Would this be something that an allergist would handle? Would he have any responsibility in either making the diagnosis or treating this particular problem?

MR. WALTERS: Objection.

MR. CHARMS: Objection.

Q. You can answer. He is just objecting for the record.

A. I can't understand the question.

Q. Okay. I will start it over again.

The pediatric allergist, what is his expertise in dealing with JNA?

MR. WALTERS: Objection. If you know.

A. I think Dr. Durve's involvement with the JNA should be limited. He should look in the nose.

Q. And beyond that, if he feels there is a problem, what should he do then?

A. Refer to a specialist.

Q. In that sense, is it your statement here today that you feel Dr. Durve did the right and

proper thing with this boy?

MR. WALTERS: Objection.

MR. CHARMS: Objection.

MR. WALTERS: Doctor, in terms of involvement of other physicians, care providers who are not parties to this lawsuit, you need not render an opinion as to the type of care they gave.

Counsel can't compel you to have an opinion as to those people. If you don't have one, or don't care to render one, just say so.

A. I prefer not to render an opinion.

Q. As to Dr. Durve?

A. Uh-huh.

Q. Also, in terms of Dr. Hostetler, you, as you previously stated, he did not refer the patient to you; is that correct?

A. That's correct.

Q. And you had no contact with him directly?

A. Correct.

Q. You never had a conversation with him; is that correct?

A. Yes.

Q. Now, on 11/22/83, the first time that you saw Little John, did you take a history?

A. Yes.
Q. And who did you take the history from?
A. Primarily from the mother.
Q. And what did she tell you at that time? You can refer to your notes if you like.
By the way, I see there are no notes from 11/22.
A. No, that is incorrect. It is just -- there is not a date right here.
Q. Those are the 11/22 notes?
A. That's correct, yes.
Q. I didn't understand that.
MR. JEFFERS: That's the initial?
THE WITNESS: Yes.
Q. Okay. Fine. Would you tell us what your history revealed at that point?
A. Sure. The patient at that time had increased nasal secretion, swelling of the right cheek area. He had been seen previously by Dr. Durve, as I said, who did skin testing for allergies with negative results.
He got an X-ray of the face at that time, which showed an apparent sinus infection.
MR. JEFFERS: What does it

say after who performed what?

A. Skin testing and rash testing, which is a blood test for allergies, negative results.

He had an additional -- do you want me to read the notes? Additional X-ray of -- I can't read that -- sinuses revealing right side to have an active infection process.

The next line is physical examination and that's the ears have in fact thick membrane, no pus coming out of ears, no infection; nose, the right side is completely blocked with what appeared to be pus.

The left side is edematous, revealing some secretions in there too. The throat, the right tonsil had a bit of tonsillitis.

That's about all that is germane to this, I think.

Q. What is this next --

A. Which line are you at?

Q. Right after where you just stopped. The next line.

MR. WALTERS: No increase in size.

A. No increase in size, yes. I think that means left tonsil. Infected, but not increased

in size.

I have trouble with that second word there too.

Q. And going on from there?

A. There are palpable nodes in the neck as we see in infected processes.

Q. Is that the end of your note for 11/22?

A. Yes.

MR. WALTERS: There is some writing below that.

A. The diagnosis at that time which was presumably right maxillary sinusitis. The treatment of Ceclor and a nasal spray to break up his secretions.

Q. Now, in addition to your note here, did you have any records at that time from Dr. Durve sent to you? Did you have the X-ray itself that had been sent to you?

MR. JEFFERS: You have to say yes or no.

A. No, I had no additional records from Dr. Durve. At the end of my day I went over and looked at the X-ray myself.

Q. That's when you drew your own conclusions that you already stated on the record?

A. That's correct.
Q. And the treatment at that time, you were assuming at that point, based on what you saw, that he had infection of the sinus?
A. Infection of the sinus probably secondary to a foreign body in the right nostril.
Q. Now, doctor, at the very beginning, did you entertain other possibilities in terms of what we would call the differential diagnosis?
A. Uh-huh.
Q. First of all, would you tell us what the differential diagnosis is as you medically understand it?
A. It could be inflammatory in nature, for example, could be allergies. It could be infection in nature; sinusitis, for example. It could be a foreign body; an eraser, for example. It could be neoplastic, for example, benign or malignant tumor, which includes what we are talking about today, a JNA.
Q. Did you on 11/22 entertain all those possibilities?
A. Yes, I did.
Q. Is it the duty of the doctor when he considers a differential diagnosis for the

benefit of the patient to rule out the most serious ones, the most life threatening and most dangerous? Is that the duty of the physician?

MR. WALTERS: Objection. You may answer.

A. I think the duty of the doctor is to get the diagnosis. Does that answer your question?

Q. In trying to accomplish the diagnosis, when he has a list of possible problems, does he have a duty to look at the most serious and rule that out first and go down in terms of severity?

MR. WALTERS: Objection. You can answer.

A. Well, I think it is not as simple as that.

Q. As you understand it.

A. It is not as simple as the question is phrased; to rule out all sorts of malignancies. For example, a CAT scan with dye injections and the child need to be extirpated and a diagnosis needs to be obtained quickly. If a diagnosis cannot be obtained, the next higher risk, modality needs to be entertained at that time.

Q. But that's what I'm trying to establish.

In order to get at the diagnosis that you say has to be done quickly, if you have a whole group, how do you rule out the other ones?

MR. WALTERS: Wait a second. We are talking in generality. I think he answered. There are some things that take a lot of testing. If you can find the answer without doing that to a kid, great, and I think that's what he said.

Q. Is that what you're saying? Are you saying that?

A. Not everything that comes in with a sinus infection needs a CT scan with angiogram.

Q. And the ones that do need that, how do you tell the ones that do from the ones that don't?

MR. WALTERS: Objection. Give him some parameters.

Q. Well, in other words, you understand I am talking in general terms, not specifically about Little John. I'm simply trying to find out in terms of a differential diagnosis, if you have a number of possible disorders present or disease processes, how do you come down to the one that you decide is the proper diagnosis?

A. Just see what you think is the most likely one, first.

Q. And what do you base that on, in general again?

A. Appearance of the patient, clinical experience, epidemiologic statistics.

Q. And based on those things on 11/22, it was your determination that none of those other processes were at work; it was mainly a sinus infection?

MR. WALTERS: Objection.

A. I didn't say that.

Q. What was your conclusion on 11/22?

A. Unilateral maxillary sinus infection, etiology to be determined.

Q. When was the next time you saw Little John?

A. 11/26.

Q. And again, doctor, I'm not trying to be redundant, but I don't see any notes for that date.

A. That was the date of surgery.

MR. JEFFERS: What is the next date?

THE WITNESS: 11/26.

Q. Did you see him first before the surgery in your office?

A. No.

MR. WALTERS: Other than what he just told you about on the 22nd.

Q. Was there anything else that occurred? Let's say, is there anything else on the 22nd that occurred that is of any significance that we have not discussed? This is the initial visit.

A. No.

Q. On that 11/22, visit, on that day, did you try to probe into John's nose at any time and try to remove anything?

A. Yes.

Q. Was there any bleeding that took place on that day?

A. No.

Q. How extensive was your probing on that first day, 11/22?

A. Superficial.

Q. Now, moving then to 11/26.

A. It was not probing. I think a better word would be trying to extirpate what was in there, assuming a foreign body in nature. That

means that first of all we cleaned out the pus in the nostril with suction, and with small forceps tried to remove whatever was in there with no luck and no bleeding. This is phychologically traumatizing to a little boy, which is why we didn't go further.

Q. Now, on 11/26, which is the second office visit --

A. No, that is not an office visit, that is the date of surgery.

Q. Well, let me try to refresh your recollection. Mrs. Lynix recalls that on that day, 11/26, she first took Little John to your office and that he had a tee shirt on and he had on white jeans. Before you went to the hospital, you were probing in the office and a lot of blood started to come out and you then decided to take him over to the hospital. Is that possible that it occurred that way?

A. A lot of things are possible. I don't recall that.

Q. You don't recall that?

A. No.

Q. Okay. Would you tell us what you do recall from 11/26? This is the second time.

A. That was the day of surgery. So now a point in fact should be made. If John was in the office and I took him over to the hospital for surgery, we would have to determine when he last ate and things of that nature, because he is scheduled as a general anesthesia. We could refer to the Parma Hospital operative schedule to see if he was an emergency add-on or whatever.

Q. Okay. Now, along those lines, I have a set -- here is a set of all of the Parma records. This may make it easier than using your own, because I have them all in order.

On that sheet, doctor, would you identify that? That's from the emergency room of Parma Community General Hospital, and the date on the top is what?

A. 11/26.

Q. Is this now the hospitalization that we are referring to?

A. Yes.

MR. WALTERS: You're looking at an emergency room sheet at the top here.

Q. Would you tell us what the complaints are listed on that sheet at that time?

A. That he has a mass in his right nostril.
Q. All right. How is it listed? It says complaints: Possible FB nose.
What does that mean?
A. Possible foreign body in nose.
Q. Okay. And the next line under that, would you read that?
A. Mother states patient to see Dr. Dvorak in ER and then to surgery to remove foreign body.
Q. And over there where the coding section is, are you familiar with what those two code sections would be; 478.1 and 21.31?
A. Probably PC codes. What they refer to, I don't know.
Q. Could we turn to the next page, please, doctor. Just flip those over.
Now, would you identify that document?
A. It is an operative report.
Q. And what is the date of surgery on that?
A. 11/26/83.
Q. Now, again, the second visit we are talking about, or the second time you have contact with Little John?
A. Yes.

Q. And would you tell us now the preoperative diagnosis? Would you read that, please?
A. Occlusive internasal mass, right nostril.
Q. Would you explain what that exactly -- what your definition of that is?
A. The right nostril is blocked.
Q. It is as simple as that?
A. Uh-huh.
Q. Post-operative diagnosis, would you read that?
A. Occlusive internasal mass, right nostril; neoplastic process.
Q. What does that part mean, the neoplastic part?
A. Something is growing there.
Q. So at this point you have changed your diagnosis from a possible foreign body to a mass or tumor of some kind; is that correct?
MR. WALTERS: Objection.
A. Yes.
Q. Now, the procedure on that page, of the operative report, the answer was general; is that correct?
A. Yes.

Q. Estimated blood loss 5cc?
A. Yes.
Q. Part way down that description on that same page, doctor, where it starts out tissue was totally occlusive, do you see that line?
A. Yes.
Q. It is about halfway down. There is an arrow there.
MR. WALTERS: On his copy, Mr. Guion put an arrow.
Q. Would you read starting there, doctor, please.
MR. WALTERS: With that sentence?
A. Tissue was totally occlusive, approximately three quarter centimeter from the caudal aspect of the nostril.
Q. Will you tell us what that means?
A. Three quarters of a centimeter in.
Q. And totally occlusive means what?
At that point it was blocked up completely?
A. Uh-huh.
Q. Okay. And would you continue to read from there on?

A. It appeared to be a cottonoid material, not unlike the appearance of a nasal tampon. Using straight biting forceps following nasal vasoconstriction with Neo-Synephrine, a Freer elevator was used and circumferentially the mass was freed from the nasal mucosa. Following this, using a straight biting forceps, the nasal mass was grasped. However, it was not freely movable. It appeared to be friable -- meaning easily breakable.

MR. WALTERS: Just read it and he may ask you questions.

A. -- as tissue was grasped and pulled toward the operator it tore.

It appeared then that this mass was neoplastic in origin and not a foreign body. The mass was 90 percent extubated from the nasal chamber and sent to pathology for a permanent section. The middle meatus was identified. However, the sinusostia were not freely identified.

Q. That's enough, doctor.

Going back now if we can talk about this a little bit. When you say using straight biting forceps, could you describe to us what

you were doing?

A. Looked like little alligator cups. A straight one like this and upbiting one like that. Trying to pull out what is in there.

Q. So you're reaching into the nose?

A. Taking in and pulling out.

Q. Pulling out chunks or pieces of this?

A. Yes.

Q. You say it was not freely movable. In other words, it was resisting?

A. Yes.

Q. And when you say friable, what does that mean?

A. Easily breakable.

Q. So as you would reach in, the pieces would break off.

And as the tissue was grasped and pulled toward the operator, it tore. What were you attempting to do; trying to pull it out all in one piece?

A. As it says, extubate, remove it.

Q. And as the tissue mass tore, it bled copiously. In other words, it was very bloody?

A. Yes.

Q. The word copiously, was that very, very

excessive?
A. Uh-huh.
Q. Then it appeared that this mass was neoplastic in origin and not a foreign body. So at this point, on 11/26, you knew you were dealing with something that wasn't a foreign body; is that a fair statement?
A. Uh-huh.
Q. Now, the statement --
MR. WALTERS: It is best if you answer yes or no.
A. Yes.
Q. However, the sinus ostia were not freely identified. What does that mean, doctor?
A. The area where the sinus drains into the back of the nose. The sinus drainage pathway point.
Q. You say it was taken from the nasal chamber, the middle meatus was identified. In other words, you could see part of what was going on, but still some obstruction.
A. The lateral aspect of the nose. It divided into three areas, the middle meatus is where the axillary comes in.
Q. So does this mean when you stopped on

11/26 that you were aware that there was still some tumor left in the face area?

A. Yes.

Q. Okay. What was the reason the procedure was terminated at that point? Was it because of bleeding?

A. Yes.

Q. Okay. Now, on the next page, doctor, this page now, would you identify that?

MR. JEFFERS: Does this have a number in the right-hand corner?

THE WITNESS: Nine.

MR. WALTERS: We have just been on one and seven and moving now to nine.

Q. This is the operating room nurses notes and surgical record; is that correct, doctor?

A. Yes.

Q. 11/26/83?

A. Yes.

Q. On this date it says 5:20 into the operating room. And time out, was that a five or six? Were you in the operating room --

A. 25 minutes.

Q. Not an hour and 25 minutes?

A. No. That's my recollection, merely.

Q. Would you read the next line there, what you wrote there, if that's your writing?

A. That's not my writing.

Q. It is the nurse's?

A. Internasal mass, etiology undetermined.

The next line says right internasal -- well, they have a mistake in spelling, but right internasal mass and biopsy. Post-operative diagnosis is the same pending path report, anesthesia is general.

What else? Would you like me to read on this page?

Q. Do you know where the blood type is? Now, is it correct to say that for this particular operation no blood was prepared?

A. Yes.

Q. Whose responsibility is it to order blood if it is to be used?

A. Mine.

Q. Yours or the anesthesiologist?

A. Mine.

Q. So you would contact the lab or what is the procedure for doing that?

A. Blood would be drawn, a type cross matched and be held in preparation.

Q. And this would be something you would do?

MR. WALTERS: Objection.

MR. JEFFERS: No. He shook his head, yes, but he would order it.

THE WITNESS: Yes, that's correct. I stand corrected.

Q. And doctor, that was not done on this particular day for this procedure?

A. No, it wasn't done.

Q. Okay. Prior to this particular day, this 11/26 when you went over to the hospital, did you have any indication that day there might be excessive bleeding? Did you feel that was a potential problem or not?

A. I thought it was a consideration to keep in mind, but I did not anticipate.

Q. You did not anticipate that you would need blood; is that correct?

A. Yes, it is correct.

Q. The next page, doctor, 8 in the corner. Parma Community Hospital, pathology report dated November 28, 1983; is that correct, doctor?

A. Yes, that's correct.

Q. And the operation is titled removal nasal

mass; is that correct?

A. Yes.

Q. Okay. And would you read for us the microscopic description as listed there on 11/30/83?

A. The specimen reveals many small pieces of a markedly necrotic lesion composed of inflammatory and fibrous elements. The inflammatory cells consist of many neutrophilic granulocytes, lymphocytes and monocytes. The fibrous tissue is markedly cellular and contains many thin walled blood vessels. In some areas the lesion shows a bizarre fibroblastic reaction. A few pieces are partially covered with irregular stratified squamous epithelium. No obvious malignant changes are seen in the material submitted for examination.

Q. And the diagnosis, doctor?

A. Benign inflammatory pseudotumor.

Q. At that point, this is the first time that you actually had a pathology report; is that correct? This is now 11/28.

A. That's correct.

MR. JEFFERS: Objection.

You mean as opposed to one called up?

THE WITNESS: Correct.

Q. Had you any prior to this time?

A. I will have to refer to the records on that. I just don't recall off the top of my head. We might have obtained a frozen section which seems appropriate at the time.

Q. But you do not reflect any of that in your office records?

A. That would not show up here. That is a verbal report.

Q. And nowhere would that be recorded in your office records?

A. In my records it would not be recorded. In the pathology department records, it may be.

Q. Okay. Now, the doctor here is Dominguez. Is that how you say his name?

A. Dominguez.

Q. Did you have a conference or verbal confrontation, if you will, with Dr. Dominguez regarding this report?

MR. CHARMS: Objection.

A. I wouldn't say we had a conversation. We just discussed the etiology of this neoplastic process.

I said, we have a lot of tissue approximately the size of a golf ball; what do you think it is? And then he told me this.

Q. When did that conversation take place?

A. Numerous times.

Q. Were you, during the course of those numerous conversations, did you relate any of the other symptomology that you were aware of that was present with Little John?

A. Goes without question I would tell him the clinical condition as such.

Q. You did relate the clinical picture to the doctor?

A. Presentation, history, methods of treatment, X-ray findings, all sorts of things.

Q. And based on all of that, this was the doctor's conclusion, benign inflammatory pseudotumor?

MR. WALTERS: He doesn't know what the doctor made his conclusion on. Objection.

MR. GUION: This is the doctor's diagnosis.

MR. JEFFERS: He doesn't know everything that was in that particular

doctor's mind, obviously.

Q. This was what the doctor conveyed to you in written form; is that a fair statement?

A. This is the written report, yes.

Q. Did you rely on this written report in any way, doctor?

A. I certainly did. These are reputable people. If he said that, I believe it.

However, I would like to also add that we were concerned about this individual, whether there would be benign pseudotumor in the right nostril, and asked that the specimens be sent to the Cleveland Clinic pathology department for a second opinion, which they did, and also sent it to the Armed Forces Institute of Pathology, all of us working in conjunction with each other to be sure the diagnosis was appropriate and in fact such.

Q. When was the request made to the Armed Forces Institute of Pathology to give you the determination of what this tumor was?

A. I cannot immediately recall.

Q. Do you recall, was it back at this time or on November 28 when the first biopsy report came to you, or was it after that?

A. Probably the time course of this situation would be for the meantime we looked at this and thought about it and saw how John was doing. The second thing we did probably four or five days later, sent it to the Cleveland Clinic Department of Pathology and had them confirm this diagnosis, and followed that to get a third opinion, we sent it to the Armed Forces Institute of Pathology in Washington.

Q. Had you known on this date that the pathology report came back with a diagnosis of juvenile nasopharyngeal angiofibroma, would that have changed your course of treatment from that day on?

A. Certainly would have. We would have immediately transferred the child to Cleveland Clinic.

Q. Doctor, on the next page, which is number 3 in the corner, the history and physical report which consists of two pages, doctor, it is dated -- the date of dictation at least is 11/29/83.

MR. JEFFERS: What page?

THE WITNESS: Three.

Q. Doctor, would you read what the chief complaint is listed there?

A. Periorbital edema and cellulitis. Two, marked premaxillary edema. Three, right nasal obstruction. Four, right nasal neoplasm; benign mass, presumably secondary to intranasal remote foreign body.

Q. And then, doctor, would you go on.

MR. WALTERS: For the record, the January admission -- not to confuse you.

MR. GUION: No. It is not. This is -- we are still talking about the history and physical report now for November 29th when he was admitted on November 30th.

MR. WALTERS: Okay, fine. It has a number 3 at the lower right-hand corner.

MR. JEFFERS: I don't have a complete set.

MR. WALTERS: Can we take a second and look at the record?

MR. GUION: Let's get this straight.

MR. JEFFERS: Harry, would you hand this to me for a second?

MR. GUION: I want to make sure we are talking about the right hospitalization also.

MR. JEFFERS: No, the one that you're looking at is from January.

MR. WALTERS: That's what I thought.

MR. GUION: It is dictated 11/29 at the bottom of the second sheet.

MR. JEFFERS: I'm sorry. It is funny, I have this in my -- -- I have date admitted, I have this in my 11/30 to 12/3, which must have been an early morning admission as opposed to this one day.

(Discussion off the record.)

Q. Doctor, referring now to the next page, which is the history and physical report, it is mentioned for Parma Community Hospital that it was dictated on 11/29/83. Can we agree that really it should have been 11/30; that this was referring to that hospitalization from 11/30/83 to 12/3/83?

A. I can't agree on the spot. I would have to go back and look at this.

Q. Would you agree that it is possibly a

typographical error?
A. It is possible.
Q. Would you read the chief complaint listed under the history and physical report.
You read that already?
A. I believe I did, yes.
Q. History of present illness of patient.
When you talk about number one, the periorbital edema and cellulitis, what does that mean?
A. Redness around the eye.
Q. To what extent? How pervasive was it in Little John on this date when you dictated this?
A. Five on a scale of one to ten.
Q. By the way, on this particular day, going back to your office visits, did you see Little John when he came in on 11/30? This would have been when he came into the hospital. Did you see him that morning when he was admitted? It is not in your office notes, but would you have seen him and examined him that morning also?
A. Yes.
MR. JEFFERS: Is there a Big John too? We keep calling him Little John. Is the father's name John, too?

MR. GUION: I call him Little John because of his size.

THE WITNESS: He has grown now. He is six or seven.

MR. GUION: Right. At the time he was five, right?

THE WITNESS: That's correct, yes.

Q. Now, 2, marked premaxillary edema, what is that exactly?

A. Red cheek.

Q. When you used the word "marked", would this be something that would stand out and be obvious to a casual observer?

A. No. I would say that was less so as compared to the redness around his eye. To an ear, nose and throat doctor, it was marked, but to a layman, I don't think it would be thought of as marked.

Q. Okay. And right nasal obstruction, your number three complaint, what was the situation there again?

A. I have gone over it. It means he had occlusion in the right nostril.

Q. This had been, again despite what had

been done on 11/26, this was still his condition on 11/30 then?

A. Yes.

Q. Right nasal neoplasm. What exactly does that refer to?

A. I must refer to our pathology report.

Q. And benign mass, presumably secondary to intranasal remote foreign body, at this point you're not considering this to be a cancerous tumor?

A. At this point our pathology report says it is a benign process.

Q. Okay. Continuing on then, doctor, would you read the next part, the history of the present illness, and I will ask you some questions as you go along.

A. The patient was in his usual state of optimum good health until approximately one month prior to this admission. At that time the patient developed first a serous and then a purulent white nasal discharge.

Q. Stopping you right there, prior to, you mentioned he had for a long period had problems. Is that an inaccurate statement then to say that he was in good health until one month

prior to November 30th?
A. According to what the mother told me, she had taken him to the pediatrician and nurses had taken cultures of the runny nose, but he didn't get precipitously ill until a month prior to when I saw him.
Q. So instead of using the optimum good health, there was a discharge from his nose for quite some time?
A. Conceivably consistent with an allergy.
Q. At that time the patient developed first a serous and then a purulent white nasal discharge. So in fact that discharge could have been back far before one month, based on what you were told?
A. Yes.
Q. Would you continue, doctor?
A. He was examined by Dr. Durve, following nasal culture by Dr. Hostetler, which revealed normal pathogens. Dr. Durve performed a number of allergic tests, including scratch tests, as well as RAST tests with no demonstrably markedly abnormal allergens noted. However, soon after being seen by Dr. Durve recently, the patient developed a constellation of

symptoms, including right maxillary cellulitis, periorbital edema, premaxillary edema, occlusive right nasal obstruction and right sided facial pain.

Q. Stopping you right there then, doctor, at this point it is now 11/30/83. Has your potential diagnosis changed? Are you now considering other possibilities other than the sinus infection that we talked about on 11/22?

MR. WALTERS: Wait a minute. He already testified after the 11/26 he knew it was a mass.

Q. What is your potential diagnosis at this point, 11/30?

MR. WALTERS: Potential diagnosis?

Q. What are the possibilities you're considering at this point?

A. Well, the most likely one seems to be based on the pathology finding that he had pseudotumor of the right nostril.

MR. JEFFERS: Do you have the pathology report there from the Cleveland Clinic on this?

MR. WALTERS: That hasn't

been handed to us yet.

THE WITNESS: No.

Q. Now, at this point, based on just what we read so far, is a juvenile nasopharyngeal angiofibroma a possibility based on these symptoms?

MR. JEFFERS: Objection.

MR. WALTERS: Show my objection.

Q. Is this something you're considering at all at this stage?

A. Yes.

Q. Okay. Would you continue on?

A. He was appropriately treated by Dr. Durve with a combination of antibiotics and decongestants with some resolution but not a complete resolution of the problem. Dr. Durve referred the patient to me, at which time a right intranasal mass was noted.

Q. Stopping at that point, doctor, at this point his vision then, you're saying, in both eyes was normal, 20/20?

A. Uh-huh.

MR. WALTERS: Say yes for the record.

A. Yes.

MR. WALTERS: Objection. Where does it say that you did a test, a visual acuity?

THE WITNESS: I did not.

MR. WALTERS: Listen to the question. How does he know if it was 20/20?

MR. GUION: He is dictating it, isn't he?

MR. WALTERS: Where does it say 20/20?

MR. GUION: It says normal. That's what 20/20 is.

THE WITNESS: Normal compared to his base line. He has an ophthalmologist and that's what I meant.

Q. Would you continue on?

A. He was placed on very intensive oral antibiotics, decongestants and nasal spray and he markedly improved. At the next visit, 48 hours following the first visit, a right intranasal mass was noted following right intranasal vaso- constriction. This was examined in the office. It was thought to be consistent with a foreign body --

Q. Can we stop there for a minute, doctor.

Before you did not recall an office visit on 11/26. Does this seem to change your opinion about that?

A. Yes.

Q. Would you be in agreement then that the mother would be correct if she said that the office visit on 11/26/83 did take place and at that time that she recalls that there was bleeding, profuse bleeding in the office?

MR. WALTERS: Wait a minute. I thought they both agreed it took place. The question is profuse bleeding?

MR. GUION: Whether anything took place in the office. He thought nothing took place in the office. I'm asking if he recalls this happening in the office.

A. I think at some extent the office records stand corrected.

Q. Would you continue, please?

A. It was thought to be consistent with a foreign body which was not able to be removed in the office. Following that examination, he was immediately taken to the operating room of Parma General Hospital --

MR. JEFFERS: Would you stop. I think this is an explanation. He has already had him in the office and many times a history and physical is not redone if the particular physician has already seen the patient, has transferred immediately to the hospital. I think you will find that's correct and that will explain the history.

MR. WALTERS: Why we don't have one for the 11/26?

MR. JEFFERS: And which that one is for the second.

Q. You can continue, doctor.

A. The first examination still was consistent with a foreign body, first cotton and then followed by a possible nasal tampon. However, upon attempted removal of the foreign body, massive bleeding incurred. It was thought to be consistent with neoplastic disease, possibly even epidermoid carcinoma. Multiple biopsies, approximately six in number, were taken. Nasal packing was placed to control epistaxis, biopsies were sent for permanent section and the initial reading was not conclusive.

This refers to the frozen section we referred to earlier.

Q. Now, all of this previous line that you just described is describing back that 11/26 first time in the hospital; is that correct?

A. Uh-huh.

Q. Okay. Continue on.

A. A reading today demonstrated this mass to be benign in nature by consensus from the pathology department of the Cleveland Clinic, possibly granulmatous reaction to a remote intranasal foreign body. CT scan of the sinuses obtained on this day revealed soft tissue mass consistent with both purulent secretions and/or neoplastic degeneration of the right maxillary sinus, the right ethmoid sinus, the base of the right orbit, the entire right nostril, all superior inferior middle meatus, not extending to the nasopharynx.

Q. Doctor, stopping right there. Your description of the CAT scan at that point is somewhat less than the actual description of the CAT scan which is, if you go just into your very next page there --

A. Uh-huh.

Q. Was there any reason not to dictate some of the other involvement that was mentioned on the CAT scan into that history and physical?

A. This is part of the hospital records. So, whoever wants to look at it could just refer to this.

Q. You felt at that point that what you were dictating into the history and physical report did not have to be complete as to what the CAT scan showed?

MR. WALTERS: Objection. We note that the exam date is the 29th. Earlier there had been a question about the dictation on the history and physical report. If it was as it indicates dictated on the 29th, that would be before the typed CT scan report would have been available. I don't pretend to know the answer to that, but I'm saying that's a possibility.

A. I think that is the answer.

Q. You mean, you did not physically at the time you were dictating the history and physical, you did not physically have that CAT scan report in your possession; is that correct? Is that what you are saying?

A. I presume at this time I had a verbal report, but not a written report.
Q. I see. Okay. Then we can just continue on. Now, let's stop anyway.
We will get to the CAT scan as the next sheet anyway. You can continue on then.
A. He is admitted at this time for intensive intravenous and antibiosis and preparation for the following procedures: One, right intranasal antrostomy, right aspiration of the maxillary contents; two, right intranasal ethmoidectomy with removal of the ethmoid contents; and three, previous to all of these aforementioned procedures, extirpation in toto of the right intranasal mass.
Q. Doctor, taking those last three things, will you explain a little bit what those are, starting with number 3, previous to all of these aforementioned procedures, extirpation in toto of the right intranasal mass?
A. Clear out the mass in the right nostril.
Q. First?
A. Yes.
Q. What was the second thing you were going to do?

A. Clear out the mass from the ethmoid sinus which is the sinus right here.
Q. That's up high?
A. Yes.
Q. That's the second step?
A. Yes.
Q. What was the last thing you were going to do?
A. Drain his right sinus, right maxillary sinusitis.
Q. So what you are saying, if I understand you correctly, on the bottom of this page, one, two, and three, you were going to completely remove this tumor and drain the sinuses?
A. Uh-huh.
Q. Is that it in a nutshell?
A. Drain one sinus, yes.
Q. Okay. Going over to the next page then, doctor.
Now again, where the physical examination is, where it says head, would you read what you have there?
A. Reveals a normocephalic skull with no tenderness.
Q. The next one, the eyes?

A. Reveals the pupils to be equal, round, react to light and accommodation with full extraocular movements and no funduscopic abnormalities, no diplopia.

Q. Now, did you do this examination yourself?

A. Uh-huh.

Q. And these were your findings?

A. Uh-huh.

Q. Could I ask you, at this time from the basis of your examination, your findings, the eyes appeared to be normal?

A. I didn't refract them.

Q. From what you did do. In other words, if you want to take it, the pupils were equal; is that correct?

A. Uh-huh.

Q. Round and react to light and accommodation with full extraocular movements?

A. Right, yes.

Q. That's all correct?

A. Yes.

Q. No funduscopic abnormalities; is that correct?

A. Yes.

Q. In other words, based on what you

examined and what you found, the eyes were normal?

A. No. I said what I said here is true.

MR. WALTERS: His findings were all normal.

Q. Your findings were all normal?

A. That's correct.

Q. Did you feel the need at this time -- and we are now talking about 11/30 -- to refer John to an eye specialist at this point?

A. No.

Q. Did you have, in fact, an ophthalmologist available at the hospital for consultation?

A. Yes.

Q. And up to this point, at least, you did not consult with any of them; is that correct?

A. That's correct.

Q. Okay. Would you read on about the nose now?

A. Reveals a left normal superior, inferior, middle meatus. Examination on the right reveals a rather friable, highly vascularized whitish mass totally occluding the superior, middle and inferior meatus.

Q. Now, when you say highly vascularized,

what does that mean?
A. Blood vessels present.
Q. You were able to determine in this mass in the nose a lot of blood vessels in it?
A. Uh-huh.
Q. Okay. The next one, the premaxillary area?
A. Reveals marked edema with no erythema, but there is visually a prominent swelling, minimal tenderness to palpation in the premaxillary area.
Q. And finally the oral cavity?
A. Reveals purulent nasopharyngeal discharge, granular pharyngitis of the oral cavity.
Q. And doctor, finally, down where it says impression, would you read that?
A. Right intranasal mass, biopsy report so far is consistent with benign neoplasm with a possibility of granulmomatous reaction to remote intranasal foreign body placement.
Q. Okay. And number 2?
A. Opacification of the right maxillary sinus.
For the record, we should state then that immediately upon taking our biopsies, pathology

specimens were sent to the Cleveland Clinic to confirm our initial diagnosis as this was a confusing complication, okay.

Q. The next morning you were about to do --

MR. JEFFERS: Did you finish the sentence?

THE WITNESS: Yes, I did, thank you.

MR. CHARMS: Let's take a quick break.

(Recess had.)

Q. We are finished with the history and physical report and ready to move on.

Doctor, would you take a look now at the next one which is the radiology examination report, page two in the right-hand side corner.

Would you identify that document, doctor?

A. Yes, I have it.

Q. Would you tell us what it is.

MR. JEFFERS: Here is my problem. What admission are we on?

MR. GUION: The original CAT scan, the one done on 11/29/83. The original CAT scan, the first one.

MR. JEFFERS: I'm with you.

Q. First, doctor, let me ask you this. Other than the X-ray which you reviewed, which was sent out by Dr. Durve prior to your first examination, is this the second time that any type of radiologic examination is done on Little John, to your knowledge?

A. Yes.

Q. Okay. Would you identify this document and tell us what this is?

A. A radiographic report.

Q. And what date is on that?

A. 11/29/83.

Q. Would you read to us, please, what it says there in that report?

A. CT study was performed on the face and orbit with attention to the right maxillary sinus site of lesion apparently benign by biopsy. Serial cuts demonstrate evidence of an extensive soft tissue mass which involves the right maxillary sinus and extends medially through the ethmoid region as well as superiorly into the right orbit. There is loss of bone with destructive change seen involving portions of the posterior wall as well as medially. There is further destruction in the

region of the posterior orbit. Extent of soft tissue mass makes evaluation of location of origin uncertain. Extension of mass into the posterior orbit is seen in the region of the optic nerve with possible visual involvement requiring clinical correlation. There is some proptosis of the right orbit noted. In view of the extensive osseous destruction radiologic findings are considered to favor a malignant lesion, however, it is possible that a benign granulomatous mass could produce these changes. No conventional studies or laminograms are available and evaluation requires clinical correlation.

CT showing extensive right facial mass with bone destruction and extension into right orbit with exact origin and etiology not determined, as above.

Q. Now, upon reviewing that CAT scan, would you tell me what this meant to you?

MR. WALTERS: Upon reviewing the report he just read to you?

MR. GUION: Yes.

A. Bone changes more commonly seen in malignant diseases than benign, but could be

consistent with pressure increases to blood supply to the bones in the area. As most X-rays, it is rather equivocal to what it means.

Q. Beyond bone changes, what else did it mean with regard to the eye, the right eye?

A. The orbit had been impinged upon in certain areas.

Q. Were you concerned about that?

A. Yes.

Q. How concerned were you? What did you do about that?

A. I followed it up with repeat CAT scan to see what was going on with the optic nerve and asking Mrs. Lynix to take her son to have an ophthalmologist see him.

Q. When did you follow up with a repeat CAT scan?

A. Well, the next day we got more X-rays, for one thing.

Q. Let's go to the next day and we will go back to the CAT scan.

The next day is the laminograms of the paranasal sinuses, the radiologist examination.

A. Laminograms of the paranasal sinuses done in the Water's and AP positions --

Q. What is the date of the laminograms?
A. The next day, 11/30.
Q. Prior to you doing the surgery on 12/1, is that correct? The next day, 12/1, you did the surgery.
Would you read what the laminograms have to say?
A. No destruction of the lateral or inferior walls of the right maxillary sinus. However, there is a generalized haziness throughout the sinus. There is bowing of the floor of the orbit upward with erosion of the medial wall of the ethmoid sinus and no clear separation is seen between the maxillary and ethmoid sinus. No abnormalities are seen in the orbit or sinus on the left. This is consistent with the mass seen on the CT examination, with destruction of the medial wall of the sinus and erosion and displacement of the floor of the orbit.
Q. Now, based on having these two radiological reports available to you prior to going in and doing the surgery, what was your plan as far as the eye, the right eye goes at that point?
A. To remove the pressure on the eye.

Q. How did you propose to do that?
A. As I indicated earlier, by removing the tumor mass from below.
Q. Did you give any consideration upon reviewing these two radiologic examinations of bringing in an ophthalmologist?
A. Uh-huh.
Q. And what made you decide against that? What reason did you decide against that?
A. No complications during surgery.
Q. I'm talking about prior to surgery, did you consider this?
A. Well, I discussed the case orally with an ophthalmologist and he said call me, I will be available if you have trouble.
Q. And who was that ophthalmologist? What was his name?
A. Dr. Coseriu, C O S E R I U.
Q. And you discussed that prior to the surgery and he said he would be available if you needed him during the surgery?
A. Yes.
Q. Did you also discuss these two radiologic examinations? I see there are two radiologists, Dr. Berman and Dr. Greenwald. Did you first of

all discuss the CAT scan findings with Dr. Greenwald?

A. No.

Q. You did not discuss?

A. No.

Q. You did not discuss --

A. No.

Q. Why is that?

A. I discussed the whole thing with Dr. Berman.

Q. Both reports?

A. Yes.

Q. And what was that conversation? What did that entail?

A. What do you think this is; there is certainly something growing there and pressing in the sinus area, in the orbital area. If you already have a pathology report --

Q. At this time you have the pathology report. You have the Parma pathology report, at least?

A. It is conceivable that the benign mass could be causing the radiographic changes.

Q. Did the radiologist give you any diagnosis?

MR. CHARMS: Objection.

A. Well --

MR. WALTERS: Wait a minute. Are you saying something other than the radiographic report, the reports that we talked about, a CT and laminogram?

Q. When you spoke with Dr. Berman, before you did the surgery on 12/1, did he give you any type of a diagnostic impression?

MR. CHARMS: Objection.

MR. WALTERS: Objection. You can answer.

A. All the findings were consistent with the pathology report we had at that time.

Q. In other words, the diagnosis of the radiologist -- this is important -- the diagnosis of the radiologist was the same as the diagnosis of the pathologist?

MR. WALTERS: Objection.

MR. CHARMS: Objection.

MR. WALTERS: Objection.

A. You can't say it in those terms.

Q. First of all, did you present to Dr. Berman a complete clinical picture the way you described to the pathologist?

A. Yes.
Q. The complete clinical picture of this patient prior to the 11/30?
A. Yes.
Q. Upon doing that and upon his reviewing with you the two radiological reports, did Dr. Berman suggest any type of diagnosis as a possibility, other than what the pathologist had recommended?
MR. JEFFERS: Objection.
MR. WALTERS: Objection.
A. Our discussion was not aimed in that direction. Dr. Berman said the X-ray findings can be consistent with the pathology report we had at that time.
Q. And did he suggest any other possibilities is what I am trying to get at?
MR. WALTERS: Objection.
MR. CHARMS: Objection.
MR. WALTERS: Objection.
A. I don't recall that.
Q. Were you aware at this point in time -- we are now moving towards the morning of --
MR. WALTERS: Are you done with 13?

MR. GUION: Yes.

Q. So you were aware -- one last thing, backing up one second to make sure there is no misunderstanding.

You were aware that there was danger to the optic nerve at this point?

MR. WALTERS: Objection.

Q. Based on reading the CAT scan?

A. Abnormality in the orbital floor.

Q. Were you aware, as stated here, that the tumor was in the region of the optic nerve?

A. Yes, I was aware of that.

Q. And possible --

A. Correlation, yes.

Q. What other clinical correlation did you do at that point besides call the ophthalmologist and ask if he would be available?

A. I examined his extraocular movements basically, and funduscopic examination, gross visual fields, and that was it.

Q. And where are those examinations recorded?

A. They are not recorded, I don't believe, other than that previous sheet we had.

MR. WALTERS: The history

and physical that was talked about.

Q. Let me ask you this question.

MR. WALTERS: Wait a second.

Q. You're now referring to what you dictated on 11 -- that's when that was done.

MR. WALTERS: Page number 4.

Q. Had Dr. Berman -- again, had Dr. Berman hypothetically told you that this could or was a juvenile nasopharyngeal angiofibroma, would that have altered your course of treatment from that point forward?

MR. JEFFERS: Objection.

MR. CHARMS: Objection.

A. I prefer not to answer questions like that.

Q. You can answer the question. Would it have altered your course of treatment had you known it was a JNA at that point?

MR. WALTERS: Objection.

You may answer.

MR. CHARMS: Objection.

MR. JEFFERS: Objection.

A. It is an involved -- do you know how we diagnose a JNA radiologically? Do you know how?

Q. How do you do that?

A. Inject dye, and it is a blood vessel study with considerable risk to the patient.
Q. What is that procedure called?
A. Angiogram.
Q. Is that a common procedure used in diagnosing JNA?
A. Yes.
Q. So it is commonly done?
MR. JEFFERS: Objection.
A. No, it is a high risk procedure. With no indication based on a pathology report that this was a JNA, the benefits would far outweigh the risks.
Q. Are there journal articles that you read in the course of your readings that say exactly the opposite; that in fact this is the technique and method of diagnosing the tumor as opposed to the biopsy?
A. I just said that.
MR. WALTERS: If you have something in mind, bring it to him.
A. I just said it is radiographic.
Q. This is referred to as what type?
A. Angiogram, arteriogram.
Q. Are these synonymous, angiogram and

arteriogram?
A. Yes.
Q. Internal, external carotidgrams now?
A. Yes.
Q. Does Parma Community General Hospital have the facilities to do that?
A. Yes.
Q. Does Dr. Berman have the --
A. State of the art equipment abilities.
Q. He does have that? But in this case, who would make that recommendation to do that procedure? Would that be you or Dr. Berman?
MR. JEFFERS: Objection.
MR. CHARMS: Objection.
MR. WALTERS: Objection.
A. Probably a joint decision.
Q. Was that decision discussed?
A. I don't recall.
Q. You don't recall whether or not you or Dr. Berman ever talked to each other about ever using this particular diagnostic procedure at this point?
A. I don't recall, because we already had one pathology report we were dealing with already.

Q. And you were basing everything on that?
A. Uh-huh.
MR. JEFFERS: Plus the pathology reports.
THE WITNESS: The two pathology reports.
Q. Then at this point we now move toward the morning of 12/1, which is when this surgery also takes place. What you said you would do in the history and physical is to entirely remove this mass; is that correct?
A. Yes.
Q. Okay. Now, at that point on 12/1 then, so I'm sure we have gone over this properly --
MR. JEFFERS: Give me a page when you get to it.
MR. GUION: I want to review some things.
Q. As you now approach 12/1, and you're going to go into surgery to remove this mass, is it correct that you knew the following things -- and this isn't from any sheets, this is just a review of everything we covered.
Number one, you knew the patient had a serous and purulent white nasal discharge prior

to 12/1?
A. Yes.
Q. You knew there was right maxillary sinusitis?
A. Yes.
Q. All of this you knew prior to the morning of the operation.
You knew there was periorbital edema?
A. Yes.
Q. You knew there was premaxillary edema and it was marked?
A. Yes.
Q. You knew there was occlusive right nasal obstruction?
A. Yes.
Q. You knew there was right-sided facial pain?
A. Yes.
Q. You knew the right intranasal obstruction was noted?
A. Yes.
Q. You knew massive bleeding had occurred upon attempted removal?
Q. Yes.
Q. You knew the mass was benign in nature at

this point?
A. Yes.
Q. You knew the CAT scan was consistent with neoplastic degeneration of right maxillary sinus, the right ethmoid sinus, the base of the right orbit, the entire right nostril, all superior, inferior medial meatus, right? You knew that?
MR. WALTERS: Do it slow. You're reading from something and he doesn't have it in front of him.
Q. What I'm basically relating to now is the CAT scan. These are things you knew before this we just covered.
The CAT scan, CT consistent with neoplastic degeneration of the right maxillary sinus, the right ethmoid sinus, the base of the right orbit, the entire right nostril, and all superior, inferior medial meatus.
A. That's an erroneous statement, I'm afraid.
Q. What is not accurate?
A. The laminogram also bowing and upper displacement on the floor of the orbit. You say there is neoplastic degeneration.
Q. I'm going back over what was said in the

CAT scan.

MR. WALTERS: You're looking at the CAT scan?

MR. GUION: Yes.

MR. WALTERS: Which one?

MR. JEFFERS: November 29th, right, Harry?

Q. What is the problem, doctor? What are you --

MR. WALTERS: The problem is you're not quoting the CAT scan.

A. I am trying to be real specific. We can't say the whole sinus has been destroyed or something like that.

Now, on page, the page that has 13 on the bottom --

MR. JEFFERS: What?

Q. The laminograms.

A. We don't have to go over all of this stuff.

MR. WALTERS: There is no question in front of you. He will ask you a question.

THE WITNESS: Okay. I think the way you stated, it is overstated. It is

not like the entire sinuses have been destroyed. There is bowing of certain bones, erosion and displacement.

Q. Let's take the sentence, the CAT scan is consistent with neoplastic degeneration of the right maxillary sinus.

MR. JEFFERS: What are you reading from?

A. Where is that line?

MR. JEFFERS: Are you reading from the CAT scan?

MR. GUION: I put together a lot of notes. I thought this came out of the CAT scan. These are all taken from notes that we have covered.

Q. Well, let me put it this way to save time. Doctor, do you agree -- if you disagree, tell me you don't agree -- that you were aware of that and if you weren't aware of it, you weren't aware.

Are you aware that it was consistent with neoplastic degeneration of right maxillary sinus?

A. Yes.

Q. Right meatus sinus?

A. Yes.
Q. That it was consistent with degeneration of the base of the right orbit?
MR. WALTERS: Where do you see degeneration in these reports? Come on. If we are going to be precise, let's be precise.
MR. GUION: The base of the right orbit.
MR. WALTERS: We have bowing. The word involvement. There is more than that.
MR. GUION: Destruction, too.
MR. WALTERS: In the CT scan there is the word destruction, but I don't see degeneration.
MR. GUION: Destruction, let's use that word then.
Q. All right. Destruction, do you like the word better than degeneration? Destruction of the base of the right orbit, you're aware of that; correct?
A. Yes.
Q. Now, the entire right nostril, this is where you said before, this is where you were having a problem the entire right nostril.
A. I have problems with that, yes.

Q. Okay. Now, how about the superior inferior middle meatus?
A. That's a problem with that, yeah. It hasn't been destroyed.
Q. Were you aware of some damage there, some destruction?
A. No, there wasn't destruction.
Q. Some invasion?
A. No, there wasn't invasion there.
Q. Anything there?
A. A mass there. Remember in my operative note with my Freer elevator, I went around it.
Q. You were aware there was a mass in that area?
A. Oh, yes.
Q. You were also aware prior to the operation that you were dealing with a rather friable highly vascularized mass totally occluding the superior medial and inferior meatus?

MR. WALTERS: Where is that from?

MR. GUION: A quote out of one of these notes that we read.

MR. JEFFERS: That was the

operative report and prior to the removal, and then 90 percent or so, was that, so that all that isn't there after one removes it.

Q. But I'm talking about on 12/1, you were aware that this was a friable mass; correct?

MR. WALTERS: What he took out was friable.

Q. Is there a presumption if what you took out was friable that remaining part would also be friable?

A. No.

Q. So you didn't know if it was friable or not is what you're saying?

MR. JEFFERS: Objection.

MR. WALTERS: Objection.

Q. Or do you know? Let them object. If they don't want you to answer, they will tell you.

A. The initial taking out more towards the periphery could have been more friable and going backwards could have been stronger, firmer.

Q. You were aware that this was a highly vascular tumor?

A. Bloody.

Q. Would you describe it as -- you did -- as highly vascularized?

A. Yes.

Q. All right.

Now, you were aware of all of these things as we move into 12/1 now, based on that. We will continue back on the 12/1.

The first thing I would like you to look at is the preoperative checklist.

MR. JEFFERS: Harry, again, if you would call off pages.

MR. GUION: 14 is in the corner.

Q. Following on that preoperative checklist, doctor, there is a number 5 which refers to blood available. And the no column is checked; is that correct?

A. Correct.

Q. Who would have made the decision prior to going into this operation -- you know now that it is a highly vascularized tumor, you know now the blood problems you had on 12/26. Who would have made the decision to order blood at this point?

MR. WALTERS: Objection.

That states he knew that what he removed on the 26th was vascularized because he had the bleeding.

THE WITNESS: Could I ask something? What happened on the 26th again? I'm getting so confused.

MR. WALTERS: The surgery where you went in with the forceps, the alligator --

Q. The date of surgery where John bled copiously, as you described it.

A. Okay.

Q. Knowing that John had bled copiously on the 26th, can you tell me, doctor, why it was, knowing you're now going in to totally remove this vascularized tumor, why you did not order the blood?

MR. WALTERS: Objection.

A. Do we have a figure on the blood loss on the 26th?

MR. JEFFERS: 5 cc. That's my memory, or was it .5?

THE WITNESS: No. It was 5.

A. I just didn't think a clinical situation required having blood on hand. Just a clinical

determination.

Q. And that was your clinical determination. Did you consult anybody about that?

A. No.

Q. The anesthesiologist is Dr. Manzano; is that correct?

A. Yes.

Q. Did he play any role at all in determining whether blood was needed at that point?

MR. JEFFERS: Objection.

A. No, he didn't play a role.

Q. Let me ask you this. Was Dr. Manzano the same anesthesiologist on the 26th when that procedure was performed?

A. I can't answer that without seeing the report.

Q. Okay. I believe he was.

Did you not discuss with Dr. Manzano anything about availability of blood at that point?

MR. JEFFERS: Dr. Manzano was the anesthesiologist on November 26th.

A. Okay.

Q. Did he in any way discuss this with you,

the need for blood?
A. We didn't think we needed blood.
Q. When you say "we", you did discuss this with Dr. Manzano?
A. Yes.
Q. And it was your joint decision that no blood would be required?
MR. JEFFERS: Objection.
Q. Is that correct, doctor?
A. Yes.
MR. WALTERS: Do we have an issue of blood loss on the November 30th operation?
MR. JEFFERS: No.
MR. GUION: We do.
MR. WALTERS: To my knowledge, we don't.
MR. GUION: Which one?
MR. WALTERS: The one you're talking about, December 1.
MR. GUION: We will get to it.
(Recess had.)
Q. Doctor, going the next page which is 22, going to the next page, would you identify,

doctor, what that document is?
A. It says nurses notes surgical record from the operating room.
Q. And what is the date of that?
A. 12/1/83.
Q. What was the time that the patient was taken into surgery?
A. 1:25.
Q. And what was the time that he was taken from surgery to the recovery room?
A. 2:35.
Q. And are we saying, doctor, that you performed this operation in the course of an hour and ten minutes; is that correct?
A. Yes.
Q. This was an hour and ten minute procedure.
Would you read what the operation involved at that point, this is the 12/1 operation?
A. Right.
Q. This is the operating room nurses notes and surgical record and read it if you can, doctor.
A. Right inter -- right internasal rhinoscopy.

Q. This was what was done on that according to the nurses notes?
A. Uh-huh.
Q. Now, again, no blood is listed on that sheet as being required; is that correct?
A. Correct.
MR. JEFFERS: Where are you looking?
A. The rest of the operation is rhinoscopy and excision of right internasal mass.
Q. Okay. These are the nurses notes; is that correct?
A. Yes.
Q. And where they normally would have blood type, that is all scratched out indicating no blood was in the operating room; is that correct?
A. I presume so, yes.
Q. Okay.
MR. JEFFERS: You mean there was no blood crossed and typed.
Q. Crossed and typed at that point?
A. Yes.
Q. We are now coming to the operative report, the first operative report. As a matter of

fact, doctor, two operations took place on that day, didn't they?

MR. WALTERS: Let him take a look at the record now.

MR. GUION: Take your time.

A. Yes.

Q. Two operations?

A. Yes.

Q. Let's talk about the first operation which was the operation on 12/1/83, the first operative report. Would you read what the preoperative diagnosis was there?

A. Extensive soft tissue mass involving, one, right nostril, totally occluding superior, inferior and middle meati; two, right maxillary antrum; three, right anterior and posterior ethmoid labyrinth; four, involving the inferior aspect of the floor of the orbit.

Q. Okay. Now, where it says the operation performed, would you read that?

A. Number one is rhinoscopy; two, extirpation of right nasal mass extending to the superior, middle and inferior meati; three, nasopharyngoscopy; four, right maxillary nasal antrostomy; five, excision of right maxillary

soft tissue mass; six, right anterior ethmoidectomy; seven, right posterior ethmoidectomy.

Q. Now, again, doctor, to take you through one of those at a time, the rhinoscopy, what exactly is that?

A. Looking in the nose.

Q. You're just looking in the nose at that point?

Number two, extirpation of the right nasal mass extending to the superior middle and inferior meati?

A. Removal of cup forceps.

Q. Is that the same biting forceps you described earlier?

A. Yes.

Q. Number three?

A. Looking at the thing that hangs in the back of the throat.

Q. To look into the nasopharynx for that purpose?

Number four?

A. Draining the right maxillary sinus.

Q. And what is the number five?

A. That's reaching into the sinus and

removing all the tissue available.
Q. And number six?
A. That's removal of tissue involving the anterior ethmoid sinus right here.
Q. Is that the one where you do the central window procedure?
A. No. That's just straight through the nose.
Q. Straight through the nose. And finally the last one?
A. I went a little bit further back.
Q. Okay. Would you read the procedure including gross findings?
A. Clinical note. This patient recently presented with approximate two month history of progressing right-sided nasal obstruction, serosanguineous progressing to purulent right-sided nasal drip, right premaxillary edema progressing to tenderness and erythema and recently right periorbital cellulitis with no orbital or occular infringement.

Preoperative radiographic examination including plain films, tomographic examination, CT scan revealed a mass to involve the entire right nostril, the right maxillary antrum, the

right anterior and posterior ethmoid labyrinth, to be involving the inferior aspect of the orbit, not to be extending to the nasopharynx, with numerous areas of bony destruction noted, more specifically including the medial wall of the maxillary sinus, the floor of the orbit, and lateral wall of the ethmoid labyrinth. Previous attempted extirpation associated with heavy bleeding revealed specimens following immediate and final diagnostic procedures including consultation with the pathology department at the Cleveland Clinic to reveal a diagnosis of pseudotumor, possibly associated with previous foreign body placement in the right nasal chamber. Due to cosmetic and functional deformities at this time the patient is admitted for extirpation of the mass.

Q. Now, at that point again you mention the fact that prior there had been heavy bleeding at that prior operation; is that correct?

A. Yes.

Q. Going down to where it says following this, will you start there.

A. Following this, the right intranasal mass was removed with the use of a number of

instruments including blunt and sharp straight and up-biting cup forceps. A large amount of tumor was removed. It was my gross clinical impression that the site of the origin of this tumor was the right middle meatus, specifically the turbinate, however, it was very hard to specifically ascertain the site of origin due to the massive involvement of surrounding structures with tumor and significant bleeding.

Q. Stopping there, doctor, when you say significant bleeding, at this point is he starting to bleed profusely?

A. When you're looking at a five year old's nose, 2 cc is a significant bleeding.

Q. Again, when you're using cup forceps, would you describe how you're taking that out?

A. The alligator type approach, bite, take out; bite, take out.

Q. These are like alligator clippers where you're reaching in the nose and pulling out pieces at a time?

A. Yes.

Q. About how many times in this procedure would you say this would be required to do?

A. Multiple times. I don't know a number.

Q. Okay. Doctor, would you continue on on the next page then. It should be noted that this --

A. It should be noted that the tumor was not infiltrating the mucus membranes of the right nostril course mitigating against so-called malignant infiltration.

Q. Let me stop you there. At this point then are you saying in a sense that you do not feel this is a malignant tumor then?

MR. WALTERS: Objection.

A. The thought in mind, it is not carcinoma.

Q. Okay.

A. Hemostasis was obtained via the use of sequential nasal packing. Following the induction of an adequate level of nasal member hemostasis, a pathway was formed from the caudal aspect of the nasal chambers through to the nasopharynx. It should be noted that clinically there was no evidence of the mass involving, extending or coming from the nasopharyngeal aperture. Following this a right --

Q. Let me stop you there for a second.

Now, after you went in with the alligator

clippers in the nose and removed what you could, are you now saying you packed the nose?

A. No.

Q. Where it says hemostasis by sequential nasal packing?

A. Packing and unpacking. I will pack until the bleeding stopped and take out the pack.

Q. And go back in the same area again?

A. Yes.

Q. And where it says it should be noted clinically there was no evidence of the mass involving, extending or coming from the nasopharyngeal aperture --

A. That is not in the nasopharynx.

Q. Was that a little bit unusual in this particular case?

A. It was consistent with our radiographic examinations.

Q. Okay. Would you continue on?

A. Following this a right maxillary nasal antral window was performed using the small size rat's tail rasp. Using an upbiting rongeur, the nasal antral window was enlarged to be approximately the size of a five cent piece. Following this the tumor was removed

using right angle instruments, once again upbiting and straight biting piecemeal.

Q. Stop again, doctor. Where is that naso antral window? Way up there?

So you're creating a window inside?

A. Yes.

Q. And continuing on with --

A. These alligator clippers are curved so I could get into the sinus right here, which is the size of a golf ball.

Q. Moving into the side of the face, right?

A. Yes.

Q. Following the normal drainage pathways under the middle meatus, an intransal ethmoidectomy was performed.

Now, what is that exactly doctor?

A. I am getting into this sinus here.

Q. From here you're now going up?

A. Yes.

Q. Okay.

A. Both the pathways under the middle meatus internasal was performed --

Q. You skipped something.

A. Both the anterior and posterior cells were removed. These were also filled with

tumor. At no time was the floor of the orbit entered or clinically in danger.

Q. Now at that point, doctor, you knew there is tumor in the orbit. You knew that the optic nerve was in potential danger. You made the decision not to go into the orbit; is that correct?

A. Uh-huh. Following the nasal antrostomy, removal of the antral mass and anterior and posterior ethmoidectomy on the right side, the procedure was terminated. Copious bleeding was observed throughout the procedure as this was a highly vascularized mass.

Q. At this point, do I understand it to mean that all the while you were doing this procedure, this boy was bleeding, bleeding, bleeding?

MR. JEFFERS: Objection. It is argumentative.

MR. WALTERS: Objection.

Q. I'm asking, was constantly bleeding, if you would prefer this?

A. From my viewpoint, it is hard to see within a nose because there is blood cells. How many are in there, it is hard to say.

Q. When you use the word copious bleeding --
A. I mean bleeding made it hard for me to see. It was not bleeding to the extent that the blood pressure fell precipitiously, as I recall, during the operative procedure.
Q. And you say again, you mention the fact this was a highly vascular recognized mass.
Is this becoming more obvious to you as you're doing this procedure?
MR. WALTERS: What?
Q. As you're pulling these pieces out, is it becoming more obvious to you that this is a highly vascularized mass?
A. Anything in the nose is bloody.
Q. At this point, having not done the operation or procedure you refer to as an angiogram, you were not fully aware of exactly what was feeding this tumor, were you?
MR. JEFFERS: What?
Q. Feeding the tumor. You were not aware.
MR. WALTERS: In terms of blood supply?
A. Correct.
Q. You were not, okay.
A. Hemostasis once again was obtained via

the sequential administration of nasal packs. At the termination of the case, the right nostril from anterior to posterior was firmly packed with one-half inch new gauze heavily impregnated with Bacitracin Suspension. A cotton pledget was placed in the caudal aspect of the nasal chamber on the right side. At this time the procedure was terminated.

Q. Stopping you right there, doctor, was the procedure terminated at that point because of the bleeding?

A. Yes. We were starting to get heavy bleeding, let's get out.

Q. Go ahead.

A. The right premaxillary edema had somewhat subsided. There was no proptosis following surgery. The oropharyngeal areas were suctioned free of mucus and blood and at this time the procedure was terminated and the patient was taken to the recovery room up to this point satisfactorily having tolerated the surgical procedure.

Q. No proptosis following surgery, what does that mean?

A. No bleeding into the orbit pushing the

eye forward.
Q. Had this been present before the surgery?
A. Proptosis?
Q. You say, the way you word it, no proptosis. Had it been present at any prior time?
A. No. It means we had not had the complication of bleeding into the orbit.
(Discussion off the record.)
Q. Let's take the second one of this.
MR. GUION: John, what we are talking about first of all is page number 9 in the corner.
Q. Crossmatch compatible. This is the sheet.
MR. WALTERS: We had a page 9 before.
MR. GUION: There are a lot of page 9's. These things get very mixed up.
He has a copy of those.
MR. WALTERS: Let me take a look.
MR. JEFFERS: Those are separate dates of one admission or multi-day admissions, and what you are doing is now page 9 of this admission of November 30 to December

3rd. They are not mixed up in terms of hospital chart.

Q. What I am going to do, doctor, obviously this is for the blood. The key thing here, would you first -- I have a question up here about patient type. Would you read what type that is?

A. B.

Q. B what?

A. Positive.

Q. And donor type is B what?

A. Negative.

Q. Does that create any problems in terms of it being different?

A. No.

Q. Why would they give a donor type of RH negative when the patient had a RH positive?

A. That was readily available.

Q. In other words, does that mean they probably didn't have the RH positive available?

A. Probably.

MR. WALTERS: Objection.

Q. Does that cause, medically speaking, harm in the fact that you're crossing the RH positive with negative?

MR. JEFFERS: Objection.

MR. WALTERS: Objection.

A. No.

Q. Okay. Now, also the date on this blood drawing is what date?

A. 12/1.

Q. Do you know where it says time started?

A. 3:15.

Q. And time stopped?

A. 4:00.

Q. Okay. And the amount transfused?

A. 250.

Q. In other words, he was removed from the operating room at 2:35 and taken to the recovery?

A. Yes.

Q. Blood was not started for 40 minutes later; is that correct?

A. That's correct.

Q. Now, we can go to the next page.

MR. WALTERS: Let me just -- you went through that last part.

I'm looking at the time. The way you had indicated was as though he were not in the subsequent surgical procedure, but go ahead.

MR. GUION: What do you mean? We are not there yet.

MR. WALTERS: I know. Go ahead.

Q. On the next sheet, would you identify that, doctor?

A. Parma Hospital recovery room record.

Q. What time does it show that Little John was brought to the recovery room?

A. 2:35.

Q. And what is the name of the admitting nurse there, the nurse in charge of the recovery room?

A. Got me.

Q. Looks like Babroski.

A. Looks like that.

Q. Are you familiar with a nurse of that name at all?

A. No.

Q. And the operation that is mentioned underneath there?

A. Where is that?

Q. Right underneath the nurses note.

A. Rhinoscopy, excision right internasal mass, right internasal antrostomy, right

interethmoidectomy.

Q. Now, he is now in the recovery room and would you start to read down there, doctor, where those notes are. First of all, the time?

A. 2:35.

Q. All right.

A. Patient on admission; 2:35, patient pale and having cyanotic.

Q. Lips could that be?

A. Lips. Ear lobes cyanotic. Unresponsive. Dr. Manzano drew blood from left jugular vein for typing and crossing. One half unit packed cells. Blood taken to lab.

2:40 patient responds to deep pain. Capillary refill poor. Patient cool to touch. Dr. Manzano unable to start IV.

2:50, Dr. Dvorak attempts cut-down at right anticubital with an IV solution, that means.

2:55 cut-down site leaking, call placed to Pediatric Services. Blood pressure not palpable. Obtainable per dopple machine, but patient -- I can't read that.

3:00 the patient was given Inderol, one milligram, per doctor. Cut-down per Dr. Dvorak.

Q. Now, as we go over to the graph on the bottom, doctor, at the admission time they have numbers there going down that column. Zero, zero and one.

At the time of admission then, based on activity, what does that zero imply?

MR. JEFFERS: Under which one?

MR. WALTERS: Where?

MR. GUION: Under here.

MR. JEFFERS: Are you asking about activity?

MR. GUION: We are going to go down the list.

Q. Zero activity when he is first brought to recovery room. What does that imply the patient's condition is at that point? Zero, able to move zero extremities voluntary or command; is that correct?

A. Yes.

Q. Respiration is one and what does that mean?

A. Limited breathing.

Q. Consciousness, what would that mean?

A. He is sleeping.

Q. Not responding; is that correct?
A. Yes.
Q. And color?
A. Blue.
Q. So --
MR. JEFFERS: I'm sorry. You said consciousness means what?
MR. GUION: Not responding.
Q. Color is blue or cyanotic; is that correct?
A. Yes.
Q. And the total is one; is that correct?
A. Yes.
Q. How would you describe as a doctor his overall condition at that point?
MR. WALTERS: At the time of admission?
MR. GUION: At the time of admission to the recovery room at 2:35 p.m.
Q. The total score of one.
A. Normal with the exception of his color was cyanotic.
Q. This would be a normal?
A. At first glance, that's the impression I have.

Q. 15 minutes later what are the activities? It is still zero; is that correct?

MR. WALTERS: Well, show my objection. We haven't covered where this patient stands with regard to the answer yet, so I mean you need to know that before you --

MR. GUION: We are going to that next, the operative procedure next.

MR. WALTERS: What I am saying, this measurement is analogous to, for example, an apgar used on a newborn. If you have a situation in which the patient is under anesthesia as opposed to when he comes out of anesthesia, it is totally different. So we need to know where they are in the anesthesia end of things.

MR. JEFFERS: Obviously he is not moving if he is anesthesized.

Q. Let's say, doctor, we do know looking at that same chart that color remains zero at admission time of 2:35; is that correct?

A. Yes.

Q. Cyanotic?

A. Yes.

Q. We know he is still cyanotic 15 minutes

later?
A. Yes.
Q. Still cyanotic 45 minutes later?
A. Yes.
Q. It is not until 90 minutes into the recovery room that his color returns to what we call pink or normal?
A. Yes.
Q. We know also at the time of admission his consciousness is zero, which is not responding; is that correct?
A. Yes.
Q. We know at 15 minutes it is still zero, not responding, and we know at 45 minutes it is still zero?
A. Yes.
Q. We know at 90 minutes it has only gone up to one and arousable on calling?
A. I wouldn't say only.
Q. It has not gone to two; is that correct?
A. That's correct.
Q. Respiration at admission is one, which we say is limited breathing or shallow. At 15 minutes still one; is that correct?
A. Yes.

Q. And it is 45 minutes later that it moves up to two, which is what we would probably call normal; is that correct?

A. Yes.

Q. Activity again is zero at admission, zero at 15 minutes and does not go back to normal until 45 minutes later; is that correct?

A. No. You can't call that normal.

Q. Two is the highest one.

A. Yes, but that is not normal. These are post-operative parameters.

Q. As high as it goes on the chart. Voluntary or on command.

A. Yes.

Q. That takes place 45 minutes after he goes into the recovery room.

MR. WALTERS: Noted at 45 minutes.

Q. That's all on that sheet, doctor.

A. I would like to point out on that sheet that his blood pressure with respect to the systolic was at nowhere near the range of not being found. It started out at a range of 160, it looks like, and the lowest point was 120. On the other hand, his diastolic was low at 20

when he came into the recovery room, which even could be related to anesthesia and gradually did come up. So you can't hang a hat on a cyanotic child, but his blood pressure did remain within acceptable bounds.

Q. So are you saying, what; overall this child was in pretty good shape when he was taken into the recovery room?

MR. WALTERS: Objection.

A. His blood pressure was still to some extent --

Q. His respiration was a little low, wasn't it?

A. He just had been intubated and asleep.

Q. Okay. Doctor, going to the operative report, page 20 now, this is the second operation the same day; is that correct?

A. This is when I put the intravenous catheters into his arm to get the blood pressure more stable.

MR. JEFFERS: In the recovery room?

THE WITNESS: This is an IV.

Q. In other words, this procedure is done in the recovery room?

A. The big time IV, that's all.
Q. Is this called an operative report here?
A. Uh-huh.
Q. And the date is what of this report?
A. 12/1/83.
Q. And the preoperative diagnosis is what?
A. Acute major blood loss.
Q. And post-operative diagnosis?
A. The same.
Q. And the operation performed?
A. Emergency bilateral antibrachial venous cut-down procedures.
Q. Now, for clarification purposes, doctor, is that where you cut both of his arms right here and here?
A. Right.
Q. You sliced through -- well, that would look like the entire distance of each arm across the width of his forearm; would that be a reasonable description?
MR. JEFFERS: Could I see what you're referring to?
MR. WALTERS: Let the record show counsel is showing the witness a photograph, I presume representing that this is

of John.

MR. GUION: Yes. This is just for clarification purposes.

Q. Doctor, would you describe what exactly this emergency bilateral antibrachial venous cut-down procedure is?

A. We wanted to bring up his blood pressure somewhat and get rid of his cyanotic color and weren't able to get into his vein. He is only five years old and we didn't have all day to be looking for veins, so I made an incision and got in quickly.

Q. Had you anticipated the blood loss, could an ankle cut-down be performed prior to surgery?

MR. WALTERS: Could?

MR. GUION: Yes.

MR. WALTERS: Objection.

Q. In other words, is this a procedure that would have been available?

MR. JEFFERS: Objection.

A. Cut-down?

Q. An ankle cut-down instead of the arms prior to surgery to prepare him if he needed blood?

A. That's not a very stable cut-down site.

Q. It is not?
A. No.
Q. In other words, what would have been the procedure, assuming you had anticipated serious blood loss?
A. What?
Q. What would you have done?
A. This one.
Q. The arms. Cut-down in any event?
A. Uh-huh.
Q. Did the anesthesiologist play any role in this?
A. He was there at the time as I just read, and he administered some Inderol to the patient to bring up the blood pressure somewhat and he was there taking care of the patient.
Q. So you were both there together?
A. Uh-huh.
Q. Would you read --

MR. WALTERS: Try to answer yes, because that gets really confusing.

Q. Would you next read the procedure, including gross findings section, please?
A. Clinical note: This patient was seen to be in extremis following radical massive

surgery for removal of right sided maxillary ethmoid, nasal soft tissue tumor.

Q. When you say the patient was seen to be in extremis, what does that mean?

A. It means we were worried that he was going to be real sick and not be able to get resuscitated and wake up.

Q. Is that how you normally define extremis, the person is really sick?

A. I usually don't define it. If you want a more appropriate definition, it means his vital signs are at risk.

Q. This patient is in danger of death; is that an accurate way of expressing it?

A. Yes.

Q. As a matter of fact, you spoke to Mrs. Lynix at some point, that you saved his life, that he was on death's door, didn't you, shortly after this procedure?

A. I may have.

Q. Okay. And you can continue on, doctor.

A. In the recovery room it was noted that his blood pressure was unobtainable. He was breathing shallowly and was thought to be markedly hypotensive from blood loss of

approximately 450 cc at the time of surgery.
Q. In other words, this procedure was due to the blood loss, there is no question about that?
A. Yes.
Q. That that was required?
A. Yes. In an attempt to resuscitate this patient, following numerous attempts at placement of venous lines with conventional means and materials and with numerous failures by myself, as well as the attending anesthesiologist, bilateral cut-down procedures were performed.
Q. Stopping right there, doctor, in retrospect, looking back on it now, if you had to do this procedure over again, would blood have been prepared in advance?
MR. JEFFERS: Objection.
MR. WALTERS: Objection.
A. If I had to do the procedure again, I wouldn't have done it.
Q. I mean, the original operation of 12/1.
MR. JEFFERS: I'm lost.
MR. GUION: This procedure obviously.
Q. The original operation on 12/1, you did

not in the morning prior to this procedure -- looking back now, knowing what you know now, would it have been wise to have blood available knowing what you do now, based on what you have and including what you knew on 12/1?

MR. WALTERS: Objection. You don't have to answer that. That is not put in proper form.

THE WITNESS: I don't mind the inquiry.

Q. Knowing what you know now in retrospect, would it have been wise to have blood available for the original procedure?

MR. WALTERS: Objection. It is the same problem. If you want to ask him what his opinion is as to what he did based upon the information he had at that time, he would be more than happy to answer it.

A. Based on the information I had, I would do it the same way. If we had a different pathology report, which we now have, I wouldn't have done the procedure.

Q. You wouldn't have done the original procedure?

MR. JEFFERS: I move to

strike. Objection.

MR. CHARMS: I join.

A. Uh-huh.

Q. Well, you have already said earlier, if the pathology report had indicated a juvenile nasopharyngeal angiofibroma that you would have done things differently. Is that all you're saying again at this point?

MR. JEFFERS: Objection.

A. Yes, I guess so. That's what I am saying, yes.

Q. Okay. Finally, doctor, just the last sentence on this page.

A. The more distal aspect of the vessel was tied off also with free tie of 4-0 chromic and following this with the use of Dopamine and large amounts of intravenous D5 and quarter normal saline, the patient's blood pressure rose --

Q. So the patient's blood pressure --

MR. WALTERS: He didn't finish the sentence.

Q. Let me interrupt you there. When you're phrasing it that way, apparently the blood pressure was low?

A. I'm having trouble with this record. If you look at the nursing record, blood pressure record, per se, it is not compatible with extremis. Throughout the procedure he has a high systolic blood pressure. His diastolic blood pressure is low, which could be for a number of reasons.

Q. Continuing on in this.

A. Clinically he removed himself from his extremis and became responsive to normal stimuli and then further resuscitative measures were not necessary.

Q. So you're using extremis at the beginning and end, right?

A. Yes.

Q. Okay. Doctor, moving on now to the next one, the discharge summary, two in the corner at the bottom, discharge summary for date of discharge 12/3/83. This is for the entire period.

(Recess had.)

Q. On the bottom of the discharge of 11/30 -- I would like you -- the date is admitted 11/30/83 and the date of discharge is 12/3/83, so we are clear on which discharge summary we

are talking about.

Would you read that final diagnosis?

MR. WALTERS: Let him read through the whole thing first and then you ask him to read.

MR. GUION: Okay.

A. Number one, extensive evasive --

MR. WALTERS: Read the whole thing to yourself and he will ask you to read specific parts.

Q. Start out up here where it says extensive evasive destructive inflammatory pseudotumor mass.

A. Okay.

Q. Involving entire right nostril with total occlusion of superior --

This is your dictation as to your description of this tumor site; is that correct?

A. Yes.

Q. Now, I have to take time to read.

And finally this part that says with extension to and into the orbits; with destruction of the floor of the right orbit, again, on the discharge of 12/3/83, you're clearly and obviously aware -- this is your

dictation -- that there is extension to and into the orbits?

A. No. There are two errors on this paragraph. Number one on the first line, instead of evasive it's invasive.

MR. JEFFERS: Which line?

THE WITNESS: Line one.

Q. Invasive?

A. And the second line from the bottom it should be orbit, not orbits.

Q. Other than that, that final diagnosis paragraph is totally correct?

A. Yes.

Q. Okay. Here is what I was thinking about before about that. Extirpation of the right intranasal mass was undertaken and the patient also had a right nasal antral window performed.

The one inside you talked about before?

A. Yes.

Q. Okay. Their narrative summary: Significant blood loss was noted at surgery, approximately 450cc was obtainable; is that correct?

A. That figure is arrived at at a combination of -- I forget. The operative note,

is that what it says?

Q. Do you have any reason to assume at this point that it was not correct?

A. It could be a combination of recovery room and inter operative procedure.

Q. Again, in your narrative summary --

A. Okay.

Q. Let me just ask you this final question.

You have no reason to assume that anything is wrong, do you, at this point?

A. No.

Q. Patient did well until his arrival into the recovery room, at which time his blood pressure was unobtainable. So there again you mentioned that the blood pressure is unobtainable?

A. I say that.

Q. He was neurologically unresponsive and he developed severe bradycardia, right?

A. Uh-huh.

Q. This was immediately ascertained to be hypotensive in origin and related to blood loss; correct?

A. Yes.

Q. And you mention at this point that

immediate cut-downs were performed in both antebrachial fossae and we were able to start infiltrating massive doses of volume expanding agents as well as typed and crossed blood. That was all done after he was taken to the recovery room; is that correct?

A. Yes.

Q. And you say he made a remarkable recovery?

A. Yes.

Q. By that you mean what; he lived?

MR. WALTERS: Objection.

MR. JEFFERS: Objection.

A. He went home in three days.

Q. Going to the next page, now, which is the pathology report. This is 19 in the bottom corner. This is the pathology report dated December 2, 1983.

Now, this pathology report is based, I assume, on tumor particles taken out during this operation on 12/1; is that correct?

A. Yes.

Q. And again, coming down to where it says -- you can review it if you want, first.

A. I'm all set.

Q. It is probably quicker if I ask you the

questions than have you read everything.

Again, where it says microscopic description, it says they reveal many small pieces of a benign neoplasm similar to that described in our previous report, okay?

A. Correct.

Q. And the diagnosis A, benign inflammatory pseudotumor; B, benign inflammatory pseudotumor, C, benign inflammatory pseudotumor, multiple pieces of.

A. Yes.

Q. Basically then what we are saying is that this pathology report on December 2, 1983 in terms of diagnosis is the same as the earlier one?

A. Correct.

Q. Okay. What exactly was your understanding, doctor, at this point of what a benign inflammatory pseudotumor was or is?

A. It is inflammatory tissue. Call it inflammatory tissue.

Q. In terms of differential, how would it differ from a juvenile nasopharyngeal angiofibroma?

A. Apples and oranges. This is benign and

the opposite is locally infiltrated and in that sense being malignant.

Q. But only in the infiltrative sense, not malignant in terms of tissue?

A. It doesn't metastasize in different places is what I mean.

Q. Only destructive by virtue of invasion?

A. Local invasion.

Q. So again to get back to the question, explain to me the way the two are different.

If you were trying to tell someone the difference in a teaching sense, how are the two different?

A. Benign inflammatory pseudotumor is a massive inflammatory tissue and it stays localized to one area and can't expand within a limited space. On the other hand, juvenile angiofibroma is locally invasive, destroys tissue, fed by copious vascular supply.

Q. So in other words, a marked difference, like you say apples and oranges, between these two tumors diagnostically?

A. Yes.

Q. Okay.

MR. CHARMS: Would you read

back the last question.

(Record read.)

MR. CHARMS: Note my objection.

Q. Doctor, the next one is the CAT scan of 12/84 where we are at. It says 9 again on the bottom.

MR. JEFFERS: What date?

THE WITNESS: 1/27.

Q. Before we do this, this will be the last time you see this patient.

Let's do this. I don't want to confuse you. I want to jump back and go through your office visits with him, okay, because this will be the last time you see him actually.

Here, this is your set of those, what we are going to do.

MR. GUION: John, I don't know how much of these you have seen.

Q. I would like to keep some continuity in time and catch up with all of the office visits and come back to the 1/27.

MR. JEFFERS: That one day admit 1/27?

MR. GUION: Where the CAT

scan is done and when he is transferred to the Cleveland Clinic.

Q. Doctor, on your first billing form here -- this is your first billing form; is that correct?

A. Uh-huh.

Q. The first bill that you sent out, would you describe what your diagnosis was at that time, what you have over in the corner there?

A. Sinusitis.

Q. And that's what you had told us previous, this was the infection that was on the 11/22 that you originally thought was going on; is that correct?

A. Yes.

Q. And your initial office visit you charged a fee of $25; is that correct?

A. Yes.

Q. Now, the next sheet, the next one on there is dated 11/26/83. That's also one of your billing statements; is that correct?

A. Yes.

Q. Okay. Would you read what you have written down there? Where you have the hospital procedure, you have surgery?

A. Excision right intranasal mass.
Q. And you charged $225 for that?
A. Right.
Q. Also, doctor, I note there are no office notes for 11/26. Is that because you just didn't record anything when you were in the office or what happened there? You have no notation.

MR. WALTERS: Let's go back to the papers that you have.

MR. GUION: I know there are hospital admission -- not admission, we said there wasn't any.

MR. WALTERS: An ER sheet for the 26th.

THE WITNESS: I presume I saw the patient at that time in ER.
Q. So again, you know you did see him in your office, because, remember, you dictated that you went from the office over to the hospital on 11/26. Do you recall that? We have been over that already. Do you remember?
A. I really can't recall, to tell you the truth.
Q. Is it accurate to say that you did see

him in your office on 11/26, based on your own statement in that dictation?

MR. WALTERS: I think he said he doesn't recall. If you have something you want to point out specifically, go ahead.

MR. GUION: This was something we had covered.

THE WITNESS: See, the other situation might be that Mrs. Lynix might have called me saying my boy isn't doing well and I said I will meet him in the hospital.

Q. This is the history and physical examination dated 11/30. You say at the next visit, the 48 hours following the first visit a right intranasal mass was noted. This was examined in the office.

A. Okay.

Q. It was thought to be consistent --

A. Okay.

Q. You have no office notes from that visit; is that correct?

A. Yeah. Negligence.

MR. JEFFERS: Harry, are these, many of these pages on this new group we are going into?

MR. GUION: Not too many.

MR. JEFFERS: Could we make copies of them so we can all see them?

Q. Doctor, now, next on this page over here are some prescription forms with various dates on them. I just want to go through them.

MR. WALTERS: These are from Mrs. Lynix?

MR. GUION: Exactly.

Q. These are four pages of prescriptions, okay. Do you see the first one there, the date is 11/26/83.

What was ordered that time?

A. An antibiotic Ceclor.

Q. And what was that for, the infection process that you thought was going on?

A. Sinusitis.

Q. And the next one is dated 12/5 and what does that say?

A. Amoxicillin.

Q. What is that?

A. A different antibiotic.

Q. What was the purpose of prescribing that?

A. If one doesn't work, maybe the other one will.

Q. Okay. And the next one?
A. Refill on Amoxicillin.
Q. And that's dated what?
A. 1/4.
Q. So at this point in January, the 4th of January, you were still treating this with this particular drug alone?
A. Yes.
Q. This is your treatment?
A. Yes.
Q. Is there any other treatment going on at that time?
A. No.
Q. Okay.
A. We might have given him some samples of decongestants from the office.
Q. I will go back over this more in detail with you.
The next page has 1/17; is that correct?
A. Yes.
Q. What is the prescription at that time for?
A. Pediazole.
Q. What is that?
A. A different type of antibiotic. Looking for one that might help him more than the other

ones.
Q. So at this point on 1/17/84 you still have the impression that you can reduce this inflammation with this type of antibiotic?
A. The premaxillary sinusitis.
Q. Okay.
MR. WALTERS: Can we have copies of those?
MR. GUION: You can have those.
MR. JEFFERS: Throw them on the side so I know they are something I want copies of.
Q. Doctor, what I would like to do is to bring us back to the present, take you through the office visits now.
After 11/26, and after the discharge from the hospital on 12/3, finally you see John again in your office on 12/5; is that correct?
MR. WALTERS: Objection to finally.
MR. GUION: I'm not trying to say that to be smart.
Q. You next see him on 12/5; is that correct?
A. Yes.

Q. Would you tell us what office notes you have from that visit?
A. Recheck post-operatively. The note suction nose free of secretions, the thought continue Amoxicillin, recheck Friday.
Q. That is the entire extent of your treatment during the 12/5 visit?
A. Yes. I examined his arms at the same time too.
Q. And what were your findings in relation to his arms?
A. Things were healing well.
Q. Did you not record that, though?
A. No.
Q. Anything else on 12/5 that you recall at this time that is not recorded?
A. No.
Q. Okay. 12/16, is that the next visit following the 12/5?
A. Yes.
Q. And would you read your notes from 12/16?
A. Well, I saw him apparently on 12/9.
Q. Okay.
A. Post-operatively.
Q. You saw him on 12/9?

A. But I have not made a notation of that.
Q. Is this 12/9 visit, in other words, are you basing the fact that you recall that simply on the billing or on the fact that it is on the bill?
A. Yes.
MR. WALTERS: Well, it says post-op check.
MR. GUION: On the bill?
MR. WALTERS: Yes.
Q. But you have no office notes for that visit?
MR. WALTERS: That's an office note.
MR. GUION: Where was that? That's a bill.
MR. WALTERS: It is part of his office notes. I don't want to get into semantics. You mean in that series?
MR. GUION: Yes.
MR. WALTERS: Apparently not. I don't see any.
Q. For that 12/9, the only thing you have recorded is the words post-op; is that correct?
A. Yes.

Q. The next record note is, or the next visit is 12/16; is that correct?
A. Yes, that's correct.
Q. Would you tell us everything you recorded from that visit?
A. Did a recheck and sutures removed from his arms. We ordered a perinasal sinus series.
Q. What is that?
A. An X-ray of the face, not of the same caliber of the CAT scan.
Q. Not of the same caliber?
A. No.
Q. In what sense is it different?
A. It doesn't show in detail what the CAT scan does.
Q. This wouldn't show anything in the eyes; is that correct?
A. Yes, it would.
Q. In the right orbit, a tumor?
A. An orbit mass will show up on a plain film.
Q. To the same extent as a CAT scan?
A. Not to the same extent.
Q. How much different is there?
MR. WALTERS: Objection.

Q. I mean, is there a marked difference in the quality of these two instruments for diagnostic purposes or almost the same?
A. Much better resolution with a CAT scan.
Q. Okay. And that report of 12/16, did you obtain it?
A. Yes.
Q. And what did that tell you?
A. He had bilateral maxillary sinusitis.
MR. WALTERS: Let's get the record --
Q. Who was the radiologist on that report?
A. Dr. Ram.
MR. JEFFERS: Do you have a copy of the report?
MR. WALTERS: It was attached in the copy of his office notes that were provided.
MR. JEFFERS: I have his notes, but I don't see that.
Q. Where it says paranasal sinuses, is that the same view that would have been ordered if you had specifically wanted to know what was going on in the right orbit?
A. These are multiple views. There would

probably be additional views to look at the orbit specifically.

Q. So you were more interested in the sinus area?

A. Yes.

Q. Would you read what that says?

A. There is evidence of bilateral maxillary sinusitis. Both maxillary sinuses are completely opacified. The other sinuses are clear.

Q. Above that where it says --

A. Routine sinus views show complete opacification of both maxillary sinuses. The frontal, ethmoidal and the sphenoidal sinuses are clear. There is hypertrophy of the nasal turbinates.

Q. How does that X-ray reconcile itself with the CAT scan of 11/29?

A. This is a post-operative view and it shows apparently that things went very well. The tumor has been removed from the ethmoid region. There is still sinusitis in the maxillary region but this is like a reassuring report.

Q. What does it say about the eye orbit?

A. This doesn't say anything about the eye orbit.

Q. So this report does not tell you in any shape or form what is going on in that area; is that correct?

A. Right.

MR. WALTERS: You mean other than absent a positive mention of it?

Q. It doesn't tell you anything positive or negatively, does it?

A. That's correct.

Q. Okay. Also while we are at it, doctor, there is one more in your notes, one more document which I would like to take a look at and that's that middle ear analyzer which was part of your records.

A. Well, I would like to point out at that visit I told Mrs. Lynix to go see her ophthalmologist.

Q. That's down here a little bit?

A. The same day as the X-ray, we still discussed it.

Q. When she comes on the next time she tells you she has seen him.

MR. WALTERS: By the way, do

you have records of that?

MR. GUION: Yes.

Q. You told her on the 16th to go see him?

A. Yes.

Q. We will get to that in a second, too.

But before we get to that, this middle ear analyzer part of your records, do you have that in front of you?

A. Yes.

Q. Would you tell us based on your review of that document, doctor, what that tells you about John's hearing?

A. That basically it is acceptable hearing in the normal range. He has a bit of a conductive hearing loss on the right side, presumably due to the post nasal drip.

Q. Did you in any way interpret the results of this document indicating that the tumor had in any way impaired his hearing?

A. No.

Q. In other words, doctor, in this document there is no reason to believe that the hearing problem would be anything other than temporary?

A. That's correct.

Q. Okay. By the way, other than the -- let

me ask you this. Other than the X-ray, prior to when he first saw you -- that was Dr. Durve's, the CAT scan on 11/29, this paranasal sinus X-ray on 12/16 -- was there any other X-ray or radiologic work done prior to this 1/27 CAT scan?

A. Well, you forgot the tympanogram done on the 29th.

Q. Okay. Including the laminograms?

A. And these parasinus X-rays and that was it.

Q. Nothing from 12/16 until 1/27/84; is that correct?

A. Yes.

Q. Doctor, now on this 12/16 visit, at that time you instructed Mrs. Lynix to take John to an eye doctor; is that correct?

A. Yes.

Q. Why did you instruct her to do that?

A. Pseudotumor is a normal tumor, generally speaking, and I wanted an ophthalmologist to check his orbits.

Q. You wanted to be sure that that tumor was not in that orbit?

A. Yes.

Q. Now, I see on the next date 12/23 you make a notation that says what?
A. Has seen Dr. Howard Siegel.
Q. Tell me this, doctor, what did Dr. Siegel tell you when you consulted about this?
A. I got all my information from Mrs. Lynix. She said after we saw Dr. Siegel he appeared to be doing fine and just continue with what you're doing.
Q. You made the referral to Dr. Siegel. You never got on the telephone and talked to him at all?

MR. JEFFERS: Objection.

MR. WALTERS: Objection. He didn't say he made the referral.

A. I asked her to see an ophthalmologist and I had one in mind. She said she wanted to see Dr. Siegel because he had previously seen John.
Q. He hadn't previously seen John, from what I understand, but he had been her doctor.
A. It is a conceivable scenario.
Q. You at no point talked to Dr. Siegel then?
A. No.
Q. Did you make any attempt whatsoever to speak to him? Did you try to write him, call

him on the phone, do anything of that sort?
A. I don't recall.
Q. Did you ever ask in any way for his report?
A. Yes.
Q. When did you do that?
A. I don't recall.
Q. When did you receive it?
A. I didn't receive anything from Dr. Siegel.
Q. By what method did you try to obtain his report? Did you write a letter to his office, call?
A. I really can't answer that, I don't recall.
Q. Is it possible you never even tried to get the report? Is that a possibility?
A. No.
Q. You have some vague recollection that you tried to obtain his report?
A. Yes.
Q. When did you do that? When did you try to obtain it?
A. I can't recall.
Q. In any event, you never did come to have the report; is that correct?

A. Correct.

Q. Okay. Now, here is his report. Here is his examination sheet, I should say. This is basically everything he wrote on this day.

MR. WALTERS: Is there a report?

MR. GUION: No. This is it, his office report.

Q. Doctor, have you had an opportunity to review that?

A. Yes.

Q. First of all --

MR. WALTERS: Let me take a look at it.

(Recessed.)

Q. Getting back to the eye examination of Howard Siegel which you refer to in your note of 12/23, has seen Dr. Siegel, have you had a chance to review his office notes?

A. Yes.

Q. Would you interpret those for us, to the best of your knowledge? I understand you're not an eye specialist.

MR. JEFFERS: I object to his interpretation.

MR. CHARMS: I join.

MR. WALTERS: He doesn't have to interpret them.

Q. Would you read what it says there and then I will ask you questions, if you want to do it that way.

MR. WALTERS: He has read it.

Q. Read it for the record. Start where it begins 12/22/83.

A. I can't read the first word.

Q. Okay.

A. Per mother. Right orbit changed due to tumor and now OD protrudes.

That means the right eye protrudes.

I imagine that's the refraction, 20 over 50 and 20 over 25. Decreased or definite decreased retrodisplacement. Right eye. Alphabet looks like angular.

Q. Okay.

A. I can't read it all, the next line.

Q. Proptosis.

A. I'm getting that line.

MR. WALTERS: There is a line before that.

Q. Displacement, no displacement?

A. Yes.

MR. WALTERS: It says something, something, something OD 15, it looks like, and then it says no displacement.

Q. Then it says what?

A. Just proptosis -- and says the right eye. I can't interpret what that line means.

Q. Okay.

MR. JEFFERS: What does OD mean?

THE WITNESS: Right eye.

A. And diagnosis is -- I just can't make any sense out of it. I don't know what that means.

Q. Based upon reviewing this record, doctor, what does this tell you about his vision on this date, which is now 12/22/83?

MR. WALTERS: Well, he just said there are parts of it he can't read.

Q. From what you can read and from what you understand this, doctor, to be saying.

MR. WALTERS: Objection.

A. On these records like this, I don't know what they are referring to.

Q. If you would have received this document on 12/22/83, are you saying it wouldn't make

any difference what you did after that?
A. No. I'm saying it wouldn't have made any sense to me.
Q. So, receiving this document -- you say you requested it -- receiving this document wouldn't have made any difference?
MR. WALTERS: He did not say he requested this document.
MR. GUION: Yes.
MR. WALTERS: A report. It looks like an office note, not a report to me.
Q. If you had received this, a copy of this document which is now in front of you, would this in any way in and of itself have altered your course of treatment from this day forward?
A. I think it would be an additional piece of data to rely on, but just a piece of data.
Q. Let me ask you this question. Not only did you not contact Dr. Siegel, is it accurate to say he never contacted you?
A. I presume so.
Q. Well, I mean, are you aware of him ever contacting you?
A. No.
Q. Okay. Do you understand what that last

line means where it says right disc margins probably old? Does that have any meaning to you?

A. Talking about popilledema, which has to do with the area around the optic nerve, but I don't know what the words are here that he is using. I can't read his writing.

Q. What is he saying about the area around the optic nerve?

MR. WALTERS: He just said he can't read the writing. If you have a translation, put it in front of him, we will look at it.

A. No.

Q. That doesn't have any significance?

A. No.

Q. Going back to your office notes, continuing on then with that.

A. Yes.

Q. 12/23, will you read what you have there?

A. Has seen Dr. Howard Siegel. Keep the patient on Amoxicillin, Entax liquid and Neo-Synephrine.

Q. And that was all your treatment consisted of on 12/23?

A. Examination of child.
Q. What did your examination reveal?
A. The arms were healing and nothing unusual was transpiring in terms of post-operative healings.
Q. How do you know that, doctor, when none of that is on your notes here?
A. I put down unusual findings.
Q. Anything unusual would be listed on your office note?
A. Yes.
Q. In other words, if it is not there, you're saying that there was nothing remarkable?
A. Yes.
Q. 1/5/84 is your next visit or his next visit to you, I should say.
A. Yes.
Q. Would you tell us what you have there?
A. Drainage from nose more pronounced on the right side. Drainage clear, no blood or pus.
Q. Wasn't this drainage ongoing from the very beginning all the way through this whole procedure. It never did stop, did it?
A. No, it never did stop.
Q. Wouldn't that be a remarkable symptom to

be noted in the earlier date?
A. Not with all this surgery; what, that the drainage hadn't stopped?
Q. And ongoing secretion from the right nostril, would this be something that you would have put into the 12/23/83 note normally?
MR. WALTERS: He just answered you.
Q. In other words, you were only putting in there things that, whatever your definition?
A. Probably at this time his whole nostril was full of sanguineous mucus and I thought that was more drainage than I would suspect.
Q. Was there any more drainage that you would --
A. No.
Q. His next office visit is 1/12/84; is that correct?
A. Yes.
Q. Would you tell us what you observed at that time?
A. At that time the drainage from the nose appeared to be more normal, clear in color and the swelling was reduced in his cheek area.
Q. Okay. And treatment at that time was

what?

A. Continuing of the above.

Q. Which was what?

A. Antibiotic, Neo-Synephrine, a decongestant.

Q. Nasal spray, in other words?

A. Uh-huh.

Q. The next office visit is on 1/20; is that correct?

A. No, 1/23.

Q. Is that 1/23?

A. Yes.

Q. Okay. 1/23.

A. Increase swelling of the cheek area, clear drainage nostrils and at the time we made an appointment with Dr. Tucker for January 31, later changed to February 21 and that's it.

Q. All right. Now, when you made that appointment with Dr. Tucker for February 21, why did you do that?

A. I needed -- I wanted to get a second opinion to make sure everything I was doing was correct.

Q. And what concerns did you have on that 1/23/84 visit?

MR. JEFFERS: Which?

MR. GUION: 1/23.

Q. What concerns did you have at that point?

MR. CHARMS: 1/20 or 1/23?

THE WITNESS: I think it is 1/23.

MR. WALTERS: We will double check.

A. The swelling in his cheek area.

Q. Is it correct, doctor, that at that time you talked to Mrs. Lynix next and you said that there is three possible teaching hospitals you would consider sending him to: One was Akron Children's Hospital; one was University Hospitals, and one was the Cleveland Clinic?

A. I don't recall.

Q. You recall having a conversation with her about this, about seeing another doctor?

A. I don't recall other places.

Q. In other words, when you made that appointment with Dr. Tucker, did you have any conversations with Mrs. Lynix?

A. Yes.

Q. What do you recall about that conversation?

A. Well, let's get another opinion and send John to another place.

Q. Did you also tell her at that time that after she got the other opinion from the doctor at the Clinic to come back and talk to you because these doctors were all big cutters at the Cleveland Clinic?

MR. WALTERS: Objection.

A. No.

Q. You don't recall a statement that she should come back to you because of that reason because you were concerned about how quick they might be to do surgery; that you wanted to do the surgery again?

A. No.

Q. You're saying you didn't have that conversation or you don't recall it?

MR. WALTERS: He already said he had conversations with her about referring her to the Clinic.

MR. GUION: I'm asking him about this.

MR. WALTERS: Is he saying did he have a conversation with her? Yes he did. He already told you that.

MR. GUION: He told me he did. I'm now asking if he recalls a specific remark that she should come back to him after she consulted with the Clinic doctor.

THE WITNESS: I doubt if I made that remark. I don't recall, but I doubt that I made that remark.

MR. GUION: Okay. I'm just asking.

MR. JEFFERS: Wait, wait, wait. This is really confusing now.

You doubt that you told her to come back and see you or you doubt that you said they are all big cutters?

THE WITNESS: Both. I probably just said, let's get a second opinion and left it at that. Let's get a second opinion to see if everything is being done that should be done, that type of thing.

Q. So as late as 1/23, your treatment at that time was still what? You were still continuing with the --

A. Uh-huh.

Q. Was it still your assumption that the diagnosis of the process at this time was

merely infection now?

A. No, post-operative healing.

Q. It was still your assumption at this point that the tumor was removed, that you had removed all of it?

A. No, not all of it. But we are dealing with a benign pseudotumor.

Q. You were aware that there was still some tumor left?

A. Yes.

Q. Now, making that appointment for February -- what was it, February 21, 1984 -- at that point, this is on --

MR. WALTERS: I think he indicated it was first made for January 31 and then apparently changed to February 21.

Q. In other words, at this point when you made that appointment, doctor, you didn't see any urgency, you didn't feel that waiting another month would be critical?

MR. WALTERS: Objection.

Q. Did you or didn't you feel another month would be critical?

MR. WALTERS: Objection. He said that at the time they called the

appointment was made for January 31, which would have been eight days after he saw him, not a month. Ultimately it was changed. But your question is with reference to how he felt at the time of the visit of January 23 and therefore your question is unfair.

Q. When it was changed to -- when was it changed to February 21?

A. I don't recall.

Q. When it was changed, did that cause you any concern?

A. I think probably other events were transpiring of seeing him in the meantime. We were holding that in abeyance depending on how he did in the meantime.

I saw him four days later.

Q. You saw him on the 27th?

A. Yes.

Q. Was that at your behest or Mrs. Lynix's?

A. It should have been at mine. I don't ask people when they want to come back.

Q. Was there any reason why you scheduled the appointment for four days?

A. Close follow up.

Q. In other words, you were concerned at

that point on 1/23 that something was wrong?
A. Yes.
Q. Would you tell us what your note of 1/27 now says?
A. Presents with continuing swelling of the right maxillary region. Noted swelling extended up to the right eye area. Perinasal swelling on the right side blurred vision on the right side.
Q. Those were all symptoms that were present on 1/27?
A. Yes.
Q. Were some of those present on 1/23?
MR. WALTERS: Some of them?
Q. Any of those that are mentioned on 1/27?
A. I just started off saying continuous swelling of the right maxillary region. That was present.
Q. Any more not listed that was present?
A. No.
Q. So all of these other ones came about after the 1/23 visit?
A. Yes.
Q. Okay. Doctor, moving back over to our 1/27 hospital records now, at this point do you

recall, this being 1/27 -- let me ask you this. Before you went over to the hospital, what transpired in terms of your conversation with Mrs. Lynix in terms of her son's condition? We are at your office still on 1/27.

A. I probably said something to the effect, if is it getting worse instead of better, let's get a CAT scan and see what is going on.

Q. Did you have her see anybody before you took him over for the CAT scan?

A. I don't recall.

Q. Might it be in the same building or nearby building to Dr. Coseriu, something of that nature?

A. I may have.

Q. Do you recall doing that?

A. I don't recall.

Q. You recall him being in your office on the 27th?

A. Yes.

MR. WALTERS: Who?

MR. GUION: Little John.

A. Uh-huh.

Q. And you recall saying he will need a CAT scan?

A. Uh-huh.
Q. And then in fact that's what you did do is send her over to the Parma General Hospital?
A. Yes.
Q. By the way, doctor, what is your relationship with that hospital? What exactly is your relationship with the hospital?
MR. JEFFERS: Objection. Like he is on the staff type thing?
Q. What exactly is your relationship with the hospital?
A. I'm on the staff. I take patients there.
Q. You get to use their facilities?
A. Yes.
Q. What do you do for them in return?
MR. JEFFERS: Objection.
MR. WALTERS: I don't know what that means.
Q. In other words, you get to use all their facilities, their operating room. You get to use their blood banks, their consultants, right?
A. Yes.
Q. What do you do for them?
MR. WALTERS: Objection. That question presumes that a physician who has

admitting privileges at hospital X must therefore do something for the hospital.

MR. GUION: It is kind of presuming that.

MR. WALTERS: Well, baloney. You don't have to answer that.

MR. GUION: I think he should answer what he does for the hospital.

MR. JEFFERS: He isn't paid by the hospital at all and it is also a legal conclusion. He receives no remuneration from our office.

MR. GUION: Did I ask if he received remuneration?

Q. Do you do anything for the hospital, is my question? Do you ever work in the emergency room? Do you ever have to do anything for the hospital?

MR. JEFFERS: As of what, the first time that he saw him, January 27th?

Q. The period we are talking about between November 22, 1983 and January 27, 1984.

MR. JEFFERS: What positions did you hold if any at that time is the question.

A. 83 to 84?
Q. From the time in question.
MR. JEFFERS: With this child.
A. I was on the staff as an ear, nose and throat physician.
Q. And what did that entail? What duties does that entail?
MR. JEFFERS: Objection.
MR. WALTERS: Objection to duties.
Q. What is the definition of being on the staff?
A. Admitting privileges.
Q. All right. And to be on the staff and to have admitting privileges, is there anything that you have to do for that?
MR. WALTERS: You mean apply to get on the staff?
MR. JEFFERS: You have to have medical licensing.
A. Medical license and Board Certified, attend meetings, that type of thing.
Q. You have to attend meetings?
A. Called by the hospital, uh-huh.

MR. JEFFERS: Objection. You have the staff and you have the hospital and they are different.

MR. GUION: I have a reason for asking it.

MR. JEFFERS: That's why I'm saying, I'm not sure he appreciates the difference, because he is not a lawyer, between what pertains to the hospital and what pertains to the hospital staff, and you know as well as I do that there are staff committees over there and he attends staff committees.

Q. Do you ever work in the emergency room?

A. Yes.

Q. During this time period?

A. I can't recall if it was this time period. I worked during my residency period.

Q. I don't mean that. I'm talking about during the year 1983, did you ever work in the emergency room?

MR. JEFFERS: From the time you first saw this patient.

MR. GUION: That's correct.

A. From November of 83, I don't know. I suppose we can find out, but I don't know.

MR. JEFFERS: I believe the answer is no.

A. I'm sure the answer is no because there is a by-law that says you can't be an attending physician and work in the emergency room.

Q. You cannot be an attending physician -- what is the hospital's definition of an attending physician? What is that? What is the attending physician?

A. I don't know the hospital's definition.

Q. What do you think that is?

A. If you're on the staff, you can't work in the emergency room.

MR. WALTERS: Listen, attending is a definition which indicates what privileges you can have after you have been there so long and different staff privileges for different doctors.

Q. When did you first gain staff privileges at the hospital?

A. I really don't recall. When I finished my residency training, which was probably in January, January 1st, 83.

Q. Okay.

MR. WALTERS: We have been

here for over three hours. Unless you show some relevance of this area, let's get on with the meat of the case. You're getting into all of our days. You didn't give any advance notice you were going to take that long.

MR. GUION: That's the way it goes.

MR. WALTERS: Courtesy is the way it goes among professionals.

MR. GUION: I need to ask some questions that I think are important, that's all. We just have to cover these things, you know. I don't care what his answers are as long as he answers them. If he wants to tell me he doesn't do anything for the hospital, fine. I'm not telling him what to say, but I would like to hear what he has to say, that's all.

MR. WALTERS: Ask a question.

MR. GUION: I don't think it is an unreasonable question.

Q. Now, on the morning of the 27th you then sent Little John over to Parma for a CAT scan; is that correct?

A. Yes.

Q. Okay. Let's take a look at that now. That's where we are at. We are now on the radiology examination of 1/27/84, page 9.

MR. WALTERS: Did we previously talk about this or not?

MR. GUION: No. We are always moving forward timewise.

MR. WALTERS: It was not in the packet that you handed him.

MR. GUION: Yes, it is. Everything is in the packet.

MR. WALTERS: He has it in front of him, page 9, 1/27/84 CAT scan.

Q. Now, what I would like you to do, doctor, that's 1/27/84, correct, the radiology examination of the date in question we are just talking about?

A. Yes.

Q. Would you read that for me and I will ask you questions.

A. CT scan of the orbits and sinuses was done with 5 mm cuts and 3 mm intervals. No injection of contrast was done. The films show a large soft tissue mass occupying all of the right maxillary sinus. There is erosion of the

medial wall of the sinus and involvement of the nasal cavity with marked displacement of the nasal septum to the left. There is also a posterior extension with erosion of the posterior wall of the orbit and break through into the middle cranial fossa. There is also superior extension into the posterior aspect of the right orbit. There is destruction of the optic canal and involvement of the retrobulbar fat and the posterior aspect of the optic nerve by the mass. Resultant proptosis is secondary to the mass effect, and in the lower part of the orbit the mass approaches globe. No erosion into the globe is seen. The extraocular muscles on that side appear intact. The mass approaches the sella turcica, but no definite erosion of the clinoids is seen. Comparison with the previous examination of 11/29/83 shows that the destruction of the posterior, medial and superior aspects of the orbit has progressed markedly and the involvement of the orbit has increased markedly.

Impression: The previously noted soft tissue mass in the right maxillary sinus and orbit has grown considerably in size,

destroying the posterior wall of the orbit and extending into the middle cranial fossa as well as growing into a rather large mass in the orbit involving the optic nerve and causing proptosis.

Q. Doctor, so what we are saying here is that this tumor now on this date is growing much larger than it has before?

MR. WALTERS: Objection to the characterization.

Q. Is that what the CAT scan is saying?

A. I think I would say it says that there is a bigger tumor and it spread to the brain as well.

Q. And spread to the brain as well. Can we assume from this CAT scan when we compare it with the CAT scan of 11/29/83 that this tumor was progressively growing larger?

A. I think it can be described as to a change.

Q. There is a change? In which direction?

A. The increase in size of the tumor.

Q. You had only two done, correct?

A. That's correct.

Q. Was there any reason why you did not

order a CAT scan between these two time periods?
A. Yes. I thought it was a judicial application of radiation.
Q. You felt --
A. I didn't want to overradiate him.
Q. Did you discuss that with Dr. Berman at any time in the interim between the two?
MR. WALTERS: Discuss what?
MR. GUION: Whether another one should have been done.
MR. CHARMS: Objection.
MR. JEFFERS: Objection.
MR. WALTERS: Objection.
A. I don't recall discussing that with him.
Q. We are down to the history and physical on the next page.
MR. JEFFERS: The same admission? 1/22, four at the bottom?
MR. WALTERS: We have it.
Q. Just on that one, doctor, that's the history and physical report of 1/27.
Would you simply read what is said there about the eyes?
A. Proptosis of the right eye. Decreased visual acuity of the right eye.

Q. Did you cover that whole thing?

MR. WALTERS: Why are we reading all of the records?

Q. The eye part?

A. Part B, pupils equal and reactive to light and accommodation. There is marked proptosis of the right eye. There appears to be a discrepancy in the level of the inferior wall. Funduscopic examination reveals spurring of the disc margins to my examination. Visual acuity is grossly decreased as well as are visual fields in the right eye.

Q. What is the significance of that spurring of the disc margin?

A. Increasing pressure of the blood around the brain pressing around the disc as it comes into the eye.

Q. The only other thing that I'm interested in on that page that you read, doctor, is the history of the present illness.

A. This patient has been in a compromised state of health following the above described surgical procedures for approximately the past eight weeks. At this time, he is noted with a one week history of the above symptoms.

Q. What is your definition when you say he has been in a compromised state of health for the last eight weeks?

A. Convalescent post surgically.

Q. Does compromised state of health, is that a term used to describe everybody that is convalescing?

MR. WALTERS: Objection. Argumentative.

MR. WALTERS: I will object.

A. I really -- it is not a term used all the time. I don't feel it has --

Q. Does it carry -- what I'm trying to get at, when you say a compromised state of health, does that just mean a recovering convalescent?

A. It doesn't imply anything particularly to me. It means he hasn't been perfect.

Q. Okay.

Q. And on the next page of that where it says impression, what is the number one there?

A. Presumed right intraorbital extension, previously diagnosed.

Q. Okay. So in other words, what you're talking about is where it was diagnosed back on 11/29/83; is that correct, with the first CAT

scan?
A. Yes.
Q. Okay. The discharge summary is the next page.
MR. JEFFERS: Page two and three of the hospital.
Q. Discharge summary again for 1/27/84.
You make the statement, you say somewhere in this paragraph you thought you had that mass completely removed; is that correct?
A. No, I say up to is complete, up to and including the floor of the orbit.
MR. WALTERS: He says, the sentence says, thought to be complete extirpation of the mass from the right nostril.
MR. GUION: Comma, all three meatus from the maxillary antrum.
Q. Would you read that so I understand it? That's why I'm asking you this.
A. I interpret this, the meaning I got, all the way to the posterior and ethmoidal cell and there might have been some left behind in the region of the orbit.
Q. Now, when you say he had also had post-operative radiologic examination which

revealed no progression of the disease, is that that 12/16 sinus scan?

A. Yes.

Q. No other ones, correct?

A. That's correct.

Q. Okay. So when you say the CAT scan, you're talking about the one just performed on 1/27 was performed in the area. The orbit was noted to be filled with presumably extension of the so-called benign inflammatory pseudotumor. It was also noted that intracranial extension of the mass had also been noted in the right temporal lobe. So it had now gone into the brain; is that correct?

A. Yes.

Q. At this point it was necessary to bring in the services of a neurosurgeon; is that correct?

A. Yes.

Q. In the eye area, in the eye orbit would an ophthalmologist been used for that part of the surgery?

A. Yes.

Q. In other words, you would not have gone into the eye orbit yourself?

A. That's correct.

Q. Okay. Doctor, the last one is the Armed Forces Institute of Pathology.

Up here there is a notation with a capital letter S and a dash and the word rush. Do you see that?

A. Yes.

Q. What does that mean?

A. I don't know.

MR. WALTERS: How would he know that?

Q. If you know. What is the date of this pathology report?

A. 30 January 1984.

Q. Now, I asked you earlier on and I'm going to ask you again because maybe with it in front of you it means something to you.

When was this requested?

MR. WALTERS: I think he said he didn't request it.

MR. GUION: He said he did request it, I believe.

Q. Didn't you, doctor, say you requested it?

MR. WALTERS: You mean making the direct contact with the Army?

MR. GUION: Either directly or talking to the other doctor.

A. It must have transpired that I asked the pathologist because I don't have the cells in my own possession. I wouldn't mail them myself or anything like that.

Q. What I am getting at, in your consultation with the pathologist at Parma Hospital, does this report, as it now sits in front of you, refresh your recollection in any way as to when you might have requested or ordered it?

A. I think earlier we established it was day four following initial surgery.

Q. Which would be way back in November. The first surgery was 11/26. We would be talking about the end of November.

What I'm concerned about is this is two months later and there is a rush order on this thing.

Has it been your experience with these reports -- have you ever ordered Armed Forces Institute of Pathology reports?

A. Uh-huh.

Q. Does a rush order take 60 days on a

biopsy?

MR. CHARMS: Objection.

MR. WALTERS: Objection.

A. I think they take a very long time.

Q. They do?

A. That's correct.

Q. I'm just asking because I don't know.

MR. WALTERS: Do you have any records from the Army?

MR. GUION: Not yet.

MR. WALTERS: I don't either.

MR. GUION: 60 days when a man is waiting for a biopsy is an awfully long time.

THE WITNESS: I can't comment on that, I don't know.

MR. CHARMS: It is not the Armed Forces, it is the Armed Forces Institute of Pathology.

MR. WALTERS: The guy who signed it says Colonel.

(Discussion off the record.)

Q. Finally, as far as the biopsy report goes, it is consistent with a typical angiofibroma; is that correct?

MR. CHARMS: Objection.

Q. Is this the first time that you become aware that you're dealing with a juvenile nasopharyngeal angiofibroma?

A. Can you tell me what the reference, this refers to?

Q. I'm assuming on this day, January 30, 1984, when this thing is sent to your hospital.

MR. JEFFERS: Sent to Dr. Dominguez.

A. I think I was informed as soon as they knew at the Clinic.

Q. Well, there couldn't have been too much time variation. He didn't go to the Clinic until the 27th; is that correct?

A. That's correct.

Q. Did the Clinic make the immediate diagnosis?

A. They did in the operating room.

MR. WALTERS: Let's not speculate. Do you want to look at the records?

Q. That's all I wanted to ask about that.

We are down to the Clinic records now. This is the last set of records.

In the sake of being human, let me see if

I want to eliminate some of my questions.

The first page, just on the last two lines, doctor, would you read those? This is the Cleveland Clinic Foundation Department of Otolaryngology and Communicative Disorders. This is a hospital discharge summary on John C. Lynix dated admission 1/22/84, date of discharge 2/2/84. I want you at this point to read the last two lines. Would you read those?

A. The remainder of the review of systems was essentially within normal limits. The patient had been given an audiogram which showed some decrease in hearing of the right ear and was told that this was due to a nerve loss.

Q. Would that be in any way tied into this tumor?

MR. WALTERS: Objection. You're asking him to pull out of one little piece there --

MR. GUION: Based on his experience with this patient for two months. He has some knowledge whether this nerve loss is tied to this tumor.

MR. WALTERS: Could it be?

MR. GUION: Could it be.

A. I have nowhere seen that tumor involved, so I think most things are conceivable, but I doubt it highly.

Q. You do not think there was any?

MR. WALTERS: Objection. He answered your question.

MR. JEFFERS: May I see that face sheet on what you were just looking at there.

Q. Now, on page 3 of this, where it says hospital course, doctor, on the second paragraph, would you just read that part.

A. On the fourth hospital day, the patient was taken to the angiography suite where carotid angiography was performed through a femoral approach. The angiography showed a large, very vascular a tumor, extending from the maxillary sinus/ethmoid area with some extension into the posterior right orbit and definite extension into the middle cranial fossa. The tumor was being fed both by external carotid and internal carotid vessels on the right side of the patient's face and brain.

Q. Now, doctor, you said that this procedure was available at Parma Hospital?

A. That's correct.

Q. And the reason that you chose not to do it earlier than when it was done at the Clinic was what again?

A. The diagnosis is benign inflammatory pseudotumor.

Q. And that was the reason that you felt this angiography --

MR. WALTER: He went all through risk versus benefit before. Let's not ask the same question.

Q. All right. The next document is 1/30 -- 1/31/84, the sector scan sinuses.

MR. JEFFERS: What is this?

MR. GUION: Sector scan sinuses.

Q. Would you read that, doctor?

A. Following angiography, very large enhancing tumor is seen causing destruction of all the bony walls of the right maxillary sinus, extending up into the orbit, nasal cavity, ethmoid air cells, and through the floor of the middle fossa including the anterior wall of the

bony carotid canal. Intracranially, the mass extends up to the level of the right anterior clinoid.

Q. Now, this examination that you have just read to us --

MR. JEFFERS: The 1/31 exam?

MR. GUION: Yes.

Q. -- this is a different approach than the different X-rays you had ordered on 12/16, isn't it?

A. Yes.

Q. The next page is the pathology report dated 1/31/84.

A. Okay.

Q. And the date is 2/3/84?

A. Okay.

Q. The diagnosis in this pathology sample is what?

MR. JEFFERS: Dated what?

A. Number one is chronic inflammation.

Number two is angiofibroma.

Q. In other words, this is not the first pathology report that you were referring to before at the Cleveland Clinic that you relied on. This one we are talking about now, this

1/31/84, this is not the first pathology report that you received from the Clinic, is it?

MR. WALTERS: When you use the word report, are you talking about a written document? I think he said he didn't know.

A. This report that you're looking at with this date, that's intrahospital correspondence. That doesn't come to me.

Q. You remember earlier on in this deposition --

A. I did.

Q. You kept referring to a particular pathology report from the Clinic, correct? That is not this report?

A. No, it is not that one. That one is annotated by many months.

Q. Annotating this one?

A. Yes.

Q. I just want to be clear, okay.

The next page, this is from the Cleveland Clinic and has a title up at the top of the page sonography, ophthalmic sonography laboratory.

MR. JEFFERS: What date?

MR. GUION: Dated 2/8/84, two days preceding surgery at the Clinic.

Q. What I want to ask you is this test available, this ophthalmologic sonography available at Parma Hospital?

MR. JEFFERS: Objection.

Q. If you know.

A. I really don't know.

Q. Have you ever ordered a test such as this one?

A. No.

Q. And what is the reason for that?

A. It is not my field.

MR. WALTERS: Objection.

Q. Not your field to find out any test available where there might be a tumor in the eye; is that correct? Is that what you are saying?

A. I said I'm ear, nose and throat. It is not the ENT.

Q. But you were involved in this case. There was an eye involved.

A. Uh-huh. I would like to point out that the ophthalmologist did not order this test, the previous one.

Q. Which previous?
A. Dr. Siegel. Is that his name?
Q. The one where you sent them for the consultation?
A. Uh-huh.
Q. And you do not know if this test is even available at the hospital or not?
A. Cross my heart.
Q. Okay. The next page is embolization of angiofibroma. Would you read that?
A. It is 2/9/84.
Q. The day before surgery?
A. Right. And the right internal maxillary artery was selectively catheterized and embolized using small particles of gel foam 80. A follow up study show 95 percent obliteration of previously described abnormal vasculature within the mass. The procedure was performed under general anesthesia and the patient was sent to the recovery room in good condition.
Q. Now, prior to your surgery on 12/1 of 83, you did not utilize embolization, did you?
A. That's correct.
Q. And why is that?
A. Because the diagnosis was benign

inflammatory pseudotumor.

Q. Had it been juvenile nasopharyngeal angiofibroma, would you have used embolization?

MR. WALTERS: Would you have?

Q. Would you have?

A. I would not have been taking care of the patient.

Q. You would have done what?

A. What is being done now; send them to a tertiary care center.

Q. Okay. The next page is the surgery report itself. Operative findings. We do have the tumor eroding through the base of the skull; is that correct?

On the first line, the first couple lines of the operative finding.

MR. JEFFERS: The date of this?

MR. GUION: 2/10 now, the date of the surgery.

Q. Totally extradural angiofibroma. Would you read that first sentence, doctor?

A. Which one?

Totally extradural angiofibroma originating into the maxillary sinus and

eroding through the base of the skull into the middle fossa without penetration of the dura.

Q. At this point, obviously again this tumor was different than it was when you saw it in your operation on 12/1; is that correct? More extensive is what I'm trying to say?

A. Yes.

Q. Your surgery on 12/1/83, there was no indication that this tumor had invaded the brain; is that correct?

A. Right.

MR. WALTERS: I'm not sure it invaded the brain.

Q. Well, it is extradural but certainly pushing it, isn't it? Isn't it pushing it to the point?

MR. WALTERS: Objection. He didn't see it.

Q. That's what the gist of the report is. Okay.

MR. WALTERS: We will let doctor whoever it is tell us that.

Q. The pathology report, again angiofibroma 2/14/84; is that correct, doctor? The biopsy pathology report on 2/14 again?

A. 2/10 here. Oh, okay, I see it.

MR. GUION: That's all I am interested in on those clinic records.

The last thing I want to do is very quickly just from the point of your opinions, from the medical literature I want to know whether you agree or disagree with some of these points and then we will be finished. These are points that I'm going to be covering that are all in the medical journals.

If you want to, I have the medical journals.

MR. WALTERS: If you're going to read quotes --

MR. GUION: I am going to read statements and ask whether he agrees.

MR. WALTERS: I want to know where the quotes are from, in what documents. Let him see it.

MR. GUION: There are 45 of these.

Q. The first one right where I have the little arrow you can read the title.

MR. JEFFERS: Read the titles.

A. Surgical Management of Nasopharyngeal Angiofibroma with Intracranial Extension.

MR. JEFFERS: Who is it by and what journal?

THE WITNESS: Edmund A. Krekorian and Ronald Kato.

Q. And it appears in the journal?

A. Obviously in the Laryngoscope. You can't get it from looking down here.

MR. WALTERS: What is the Volume? Do you have the Volume?

MR. GUION: I just have what I have here.

MR. WALTERS: We can't find -- apparently this was presented at the meeting of the Middle Section of the American Laryngological, Rhinological and Otological Society in Minneapolis, Minnesota January 25, 1976, but this is a reprint from what? From the Laryngoscope?

THE WITNESS: I can tell. I don't know what journal or what volume number.

MR. WALTERS: That's the best we have.

Q. All I want you to read is that first

sentence there on this one.
A. Nasopharyngeal angiofibroma is a fascinating, challenging and sometimes fatal benign tumor.
Q. Do you agree with that, that it is sometimes a fatal benign tumor?
A. I just --
MR. WALTERS: Maybe we will have to go to the court and have him relieved of this burden. I'm not going to play it your way.
MR. GUION: All I want him to do is answer some specific statements. He can agree or disagree. I don't see the problem.
A. See, that sentence, I want to know statistics.
Q. Is it sometimes a fatal benign tumor?
A. It seems to be a contradiction in terms to me.
MR. WALTERS: Fatal and benign?
THE WITNESS: Yes.
MR. WALTERS: Sounds rather contradictory.
A. Okay, I will agree with that.

Q. All right. And the same article, if you will read that page 156.

MR. WALTERS: Can we mark this as an exhibit? Everything else is hospital records.

MR. GUION: I can make copies.

MR. CHARMS: While we are on the record, I would like copies of all the articles that you're going to examine this witness on today.

MR. JEFFERS: Also for me too.

MR. WALTERS: Me too. That's why I suggested marking them as Exhibits.

MR. GUION: If I'm going to give you copies then you don't have to know. I have little detail on volume and pages.

MR. WALTERS: If you're going to come back and ask about these, it would be easier.

MR. JEFFERS: So you can read the record.

(Recess had.)

- - - - -

(Thereupon, DVORAK Deposition Exhibits 1 through 22 were mark'd for purposes of identification.)

- - - - -

Q. Exhibit No. 1 we are referring to now, doctor. Would you go to page 156. You already answered 156.

MR. CHARMS: Before you go on. Are these going to be attached to the depo and we will all get copies of them?

Q. 156 where the arrow is, doctor, I will read and at the same time you can follow along: An angiographic assessment should be made of the relationship of the intracranial vessels to intra and extracranial tumor.

Do you agree with that?

A. That is so out of context.

Q. In reference to the juvenile nasopharyngeal angiofibroma.

MR. WALTERS: He said it is out of context. It doesn't say when.

A. It isn't like someone walks in your office. We are in the middle of a big article. You have to read it. I just can't skip from page one to page five and do something like

that.

MR. WALTERS: Obviously, and I don't know where we are going to run into this again, but on this Exhibit 1, obviously we are talking about a situation in which there has been a diagnosed angiofibroma.

MR. GUION: Not a diagnosed one. There might be one.

MR. WALTERS: I'm reading what they are talking about.

THE WITNESS: This is not a treating angiofibroma.

MR. WALTERS: And the mere title of the surgical management of nasopharyngeal angiofibroma.

Q. Differentiate between treating as opposed to diagnosing, I can deal with that.

Let me -- I understand what you're getting at. We are both here concerned more with the diagnosis, but to some extent we are with the treating also.

In this regard, on 12/1, had you known it was a JNA and had you decided to do the procedure, then these issues would become important. It would be important to do the

angiogram, wouldn't it?

A. Is there an article saying what happens with benign pseudotumor? Does everybody get angiograms? Do you have an article like that?

Q. With the benign pseudotumor?

A. Does somebody recommend that?

Q. No, because you already told us how you can differentiate that.

A. I think that would be a germane article.

Q. Well, let me see how we are going to do this. In other words, you feel that statement is out of context.

Let's go through these and you do what you want with them.

On page 157 there is a little point there. You see where that arrow is, doctor, would you read that?

A. The dominant principle in the extracranial removal of angiofibroma is adequate exposure.

Q. That's a rather straight forward statement. Do you agree with that?

A. I'm not a neurosurgeon. It says extracranial.

MR. WALTERS: He is talking about that and then he says except for small

localized tumors, the preferred technique utilizes some form -- and it goes on and on about the surgical techniques.

Q. If I were to change this and say the dominant principle in the intracranial removal of angiofibroma is adequate exposure -- in other words, is adequate exposure important?

MR. JEFFERS: For surgery?

MR. GUION: Yes.

MR. WALTERS: To have a field.

Q. Is it important to know the extent of this tumor prior to surgery?

A. You can make a statement like that, sure.

Q. Okay.

MR. JEFFERS: May I ask a question? Are we on Exhibit what now?

MR. GUION: One.

Q. Now, we are going to go on to number 2 again.

MR. WALTERS: Let me quickly state Intracranial and Extracranial Nasopharyngeal Angiofibroma, in the Archives of Otolaryngol, Volume 102, June 1976 page 371 and following.

Q. Would you just read that little section there?

A. There is no evidence of spontaneous tumor regression. This highly vascular benign neoplasm has a propensity to invade surrounding tissue and erode bone.

Q. Do you agree with that?

A. Yes.

Q. Okay. On page 373, we will just go through the essentials.

MR. WALTERS: Let the record show you're taking sentences out of the middle of the paragraphs.

MR. GUION: This is obvious. I am trying to hit some main points.

Q. Would you read that?

A. The unequivocal essentials for diagnostic evaluation to determine the extent of neoplastic involvement and blood supply are bilateral external and internal carotid angiograms.

I'm not arguing with any of that.

Q. Article number 3 on page 316, this is Exhibit 3.

MR. WALTERS: Let me get the

title. Number 3 is apparently Surgical Treatment of Invasive Angiofibroma by G. M. English, Hemenway and Cundy, Archives, Volume 96, October 1972, page 312 and following. And you're asking him about 316.

Q. The cure rate.

A. The cure rate for this benign disease should be high when the entire tumor is removed.

Q. Do you agree or disagree with that?

MR. WALTERS: Show my objection. You may answer.

A. Yes.

Q. Now, on that same page, this is one more statement marked, a symptom of --

A. A symptom of unilateral nasal obstruction in a young man should alert the physician to the possibility of a nasopharyngeal angiofibroma.

Q. Do you agree with that?

MR. WALTERS: Objection.

A. Yes.

Q. Yes, okay.

MR. WALTERS: I'm going to object to going through all of these. It is burdensome. It is not the role of the

physician to go through all of this.

Q. Just the first one.

MR. WALTERS: Exhibit No. 4, Management of Nasopharyngeal Angiofibroma, Vancouver, Canada, the Journal of Otolaryngology. This is apparently Volume 6, Number 3, 1977, page 224 and following and you're asking him about 226.

Q. Would you read that?

A. The diagnosis of juvenile nasopharyngeal angiofibroma should be suspected from the history and routine otolaryngolical examination.

Q. Diagnosis of JNA, we agree with that.

MR. WALTERS: I'm going to object to that. That is so totally out of context. It appears on like the third page of the article.

MR. GUION: It is a separate sentence.

MR. JEFFERS: To save time on the record, every time Steve objects, I object, so we don't hear it. And the same thing for you, right?

MR. CHARMS: Yes.

MR. JEFFERS: We all are

objecting.

MR. CHARMS: I think one objection for all three of us.

A. That's a fallacious statement.

MR. CHARMS: Why don't you take objection to the entire line of questioning?

A. I don't agree with that.

Q. On that same page, doctor.

A. The typical vascular pattern of the tumor virtually confirms diagnosis of angiofibroma.

Q. Do you agree or disagree?

MR. WALTERS: Objection.

A. I agree.

Q. On the same page?

A. We feel the biopsy of an angiofibroma is contraindicated. If a systematic evaluation is performed as described above, there is no need to subject the patient to the risk of biopsy in order to make a definitive diagnosis.

Q. Do you agree with that?

A. We feel that an aggressive surgical treatment is indicated in all patients with nasopharyngeal angiofibroma.

No.

MR. WALTERS: Objection. What year is this article?

A. This article is in 77. Since then embolization has become more standard. I disagree and gave you the reason.

MR. WALTERS: What are you saying, Harry, go right in there and operate?

Q. So you disagree on that?

A. That's an old article.

Q. Okay. On Exhibit 5, on the next page.

MR. WALTERS: Exhibit No. 5 is Juvenile Angiofibroma, a More Rational Therapeutic Approach Based Upon Clinical and Experimental Evidence by Dr. Ward, Dr. Thompson and Dr. Calcaterra. I think this is from the Laryngoscope, apparently 1974. It is even older than the other one.

As best I can tell, that is what it is from -- pages 2181 and following. He is asking about 2182?

A. Number two, bilateral selective external and internal carotid arteriograms are an unequivocal essential to the diagnostic work up of patients with angiofibromas.

Q. Do you agree with that?

A. Yes, I am in agreement.
Q. On page 2192, the same article.
MR. WALTERS: Let the record show, by the way, that this is a 14 page article that we are looking at.
A. It is felt that the clinical impression of angiofibroma need not be confirmed by biopsy which may result in severe bleeding but must also be confirmed by arteriograms with are diagnostic.
Q. Do you agree with that?
MR. WALTERS: Objection.
A. Yes.
Q. Okay. The next article number 9, this is Exhibit No. 6.
MR. WALTERS: Let me read it into the record. From Laryngoscope May 1974, Volume 84, Number 5. The article is Angiofibroma, a Treatment Approach by Dr. Biller, beginning on page 695 and running apparently through page 705, an 11 page article.
Q. 696.
MR. WALTERS: Are we down to parts of sentences now?
MR. GUION: Well, there is

more to it.

A. This reads and frequently increases hospital stay.

Q. No, that's wrong. Where the sentence begins.

A. Arteriography presents a vascular configuration which is diagnostic of angiofibroma.

MR. WALTERS: Doctor, if any of this stuff is too out of context to be able to comment, say that.

MR. GUION: These are straight sentences.

MR. WALTERS: I don't want to argue with you. You don't have to agree or disagree if you can't tell from the full article, but go ahead.

Q. Do you agree with that?

A. Don't you want me to read the next sentence? Arteriography avoids biopsy and at the same time yields indispensable information as to the extent of the tumor. Yeah.

Q. Do you agree with that?

A. Yes.

Q. Further on that same page there is

another section, 696?

A. Frequently obscures accurate tumor assessment.

Q. Since the extent of tumor involvement dictates the surgical approach or approaches, arteriography is deemed necessary in all patients. Do you see that there?

A. Yes.

Q. Do you agree with that?

MR. WALTERS: Objection. Again, all of these are referring to a situation where a surgeon has been given a situation that there is an angiofibroma and then these talk about what you do to determine the extent of it --

MR. GUION: No they don't.

MR. WALTERS: Let me finish my statement. And they go on and indicate that you do an angiogram to determine the extent of the tumor so you can then plan the extent of your surgery. They bear no relationship to the situation which Dr. Dvorak was presented.

MR. GUION: They are talking about diagnosis over and over again.

Q. This one article is Exhibit No. 7.

MR. WALTERS: Exhibit 7 is called the Surgical Treatment of Juvenile Nasopharyngeal Angiofibroma by Dr. Jafek, et al. It appeared, apparently in the Laryngoscope February of 1973, 13 years ago. It is Exhibit No. 7 and pages 707 through 719. You want him to look at --

Q. 713?

A. Piecemeal removal is to be avoided, as it may result in increased bleeding and incomplete tumor removal. The resultant cavity is also carefully inspected for residual occult extensions of the neoplasm.

Q. As applied to a JNA; is that true?

A. Yes.

Q. Number 12, Exhibit 8, page 109.

MR. WALTERS: Exhibit 8 is Radionuclide Angiography in Juvenile Angiofibroma of the Nasopharynx. This is from the Annotated.

THE WITNESS: Annals of Otolaryngology.

MR. WALTERS: Volume 84, 1975.

Q. Is that a reputable medical journal,

doctor?
A. Uh-huh.
MR. WALTERS: Pages 107 through 111.
Q. Page 107, doctor.
MR. WALTERS: We do have a continuing objection to all of this.
MR. GUION: All of this.
A. Juvenile angiofibroma of the nasopharynx is a highly vascular benign neoplasm exhibiting malignant characteristics by local destruction and a tendency to recur following incomplete removal.
Q. Do you agree with that statement?
A. Taken from the early article we referred to, verbatim.
Q. How about on 109?
A. Due to the high degree of vascularity, life threatening hemorrhage is a constant concern.
Q. Do you agree with that?
MR. WALTERS: Objection.
A. Yes, I would say concern.
Q. Okay.
MR. GUION: I will take 9

out. We wouldn't want to be redundant.

Q. Now we have moved to Exhibit 12.

MR. WALTERS: Exhibit 12 is titled A Few Points in the Management of Juvenile Nasopharyngeal Angiofibroma, May 1984, Volume 98. This article begins on page 489 and runs through page 492 and it is by Dr. P. Chatterji, et al.

Q. Page 489, please, doctor?

A. Okay. The removal of a massive nasopharyngeal fibroma with profuse hemorrhage is fraught with danger to life.

Q. Do you agree with that statement or disagree?

MR. WALTERS: Objection. Did somebody die of a profuse hemorrhage?

A. Well, see, I agree with that.

Q. Okay. And here is one from the Cleveland Clinic: This is number 13. Dr. Levine who did the surgery.

MR. WALTERS: Diagnosis of Juvenile Angiofibroma by Computed Tomography, Dr. Meredith A. Weinstein, Howard Levine, Paul Duchesneau and Harvey Tucker. This is from, I think this is their inhouse publication.

Q. Is that an authoritative medical journal?

MR. WALTERS: Radiology Volume 126, March 1978.

Q. Is that an authoritative medical journal?

A. Yes.

Q. 703.

A. Juvenile angiofibroma is the most common benign tumor of the nasopharynx.

Q. Do you agree with the next one?

A. 91 percent of these patients nasal obstruction was the most common presenting complaint and was combined with spontaneous epistaxis in 59 percent.

Q. Do you agree with that?

A. Yes.

Q. Do you agree with page 704?

MR. WALTERS: You know, you're skipping over sentences. It says tumor usually arises eccentrically from the roof of the anterior nasopharynx or from the posterior nasal fossa and then it goes on with percentages.

MR. GUION: I want to know if he agrees with the parts.

MR. WALTERS: I want the

record to show the context in which the questions are being asked.

MR. GUION: You will have the whole article. You can use the article any way you like.

Q. Page 704 next?

A. In most instances, juvenile angiofibroma can be differentiated clinically from other benign nasopharyngeal tumors such as ordinary fibroma and nasal polyp by the age, sex, symptoms, physical findings and by the location and extent of the tumor.

Q. Do you agree with that?

A. Yes.

MR. JEFFERS: What is the date of that article?

MR. WALTERS: This is 1978.

Q. And the next one on that page, doctor, there is one more?

A. If surgery is contemplated, angiography with embolization to decrease intraoperative bleeding is helpful.

Q. Do you agree with that?

MR. WALTERS: I'm going to object to all of these questions.

Q. Back on 704, I'm sorry. That's on page 704 again, over there. I don't believe we covered that one.

A. The diagnosis of juvenile angiofibroma by non-invasive means is desirable because a biopsy may result in uncontrolled bleeding.

You're being redundant again.

Q. Do you agree with that?

A. Yeah, I agreed the first time we said that.

MR. WALTERS: Objection.

Q. Let's go on. Let's see if I can skip through some of these. I don't want to be repetitive. A lot of this is repetition.

MR. WALTERS: I believe that.

Q. Let's jump up to Exhibit No. 21.

MR. WALTERS: Juvenile Nasopharyngeal Angiofibroma Radiographic Aspects, two through whatever. I can't tell. It is cut off, but looks like it is at least 15 or 16 pages long. Dr. Roy B. Sessions, et al, apparently coming from the Laryngoscope, January 17, 1975.

Q. Doctor, would you go to page 2 on that one. For the first statement --

A. Because of consistent and unique radiographic features in JNA, it is not necessary, nor is it advisable, to biopsy these tumors to establish a diagnosis.

Q. Would you agree with that, doctor?

A. Yes.

Q. The next one is on page 3, the next page?

A. The actual diagnosis of the JNA can be made --

Q. Because of the dangers of massive hemorrhage --

MR. WALTERS: I object. Show my objection to him being asked to comment on, agree or disagree on something that is apparently written from the standpoint of a radiologist and concerns radiographic techniques and methods.

Again, doctor, you don't have to agree or disagree on this thing.

MR. GUION: He can agree or disagree based on what he wants. That's up to him, but let me find what I want him to read and he can make his own decision.

MR. CHARMS: Over and above that, Dr. Dvorak has never qualified himself as

an expert in the practice of radiology, radiologic diagnostic techniques, and I think if the doctor is not conversant with the standards of care for a radiologist, if he is not familiar with the standards of care for a radiologist, under those circumstances or any other circumstances, with all due respect to him, he is a fine otolaryngologist, he is not competent to render those opinions as they relate to a radiologist, so with that, I will renew my continuing objection to the entire, whatever you want to call this; but certainly as it relates to Dr. Dvorak and radiologists.

MR. JEFFERS: Would you let me have that objection too.

Q. Because of dangers --

A. The actual diagnosis of the JNA can be made consistently by radiologic techniques. Because of the dangers of massive hemorrhage, biopsy is not recommended prior to the time of surgical excision; in fact, biopsies can at times be misleading, owing to the fact that the periphery of the lesion may not be histologically representative of its interior.

Q. Do you agree with that?

A. I agree with that.

MR. JEFFERS: Read the last part of that.

MR. WALTERS: The periphery of the lesion may not be histologically representative of its interior. Up above.

MR. GUION: We will stop there. That's enough.

MR. CHARMS: I have just two questions.

CROSS-EXAMINATION OF KENNETH DVORAK, M.D.

BY-MR. CHARMS:

Q. Dr. Dvorak, do you have any criticism of Drs. Greenwald or Berman or the radiologists at Parma Hospital with regard to John Lynix?

A. None at all.

Q. Do you have any criticism of the pathologists at Parma Community Hospital with regard to the Lynix boy?

A. None at all.

CROSS-EXAMINATION OF KENNETH DVORAK, M.D.

BY-MR. JEFFERS:

Q. Let me ask you, do you have any criticism of the treatment provided by anybody at Parma

Community Hospital during any of the stays of Little John?

A. No. None at all.

MR. JEFFERS: Thank you.

MR. GUION: No further questions.

MR. WALTERS: We will read it.

(Signature not waived.)

- - - - -

CERTIFICATE

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

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, KENNETH DVORAK, M.D., was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 1st day of August, 1986.

Vivian L. Gordon

Vivian L. Gordon, Notary Public
within and for the State of Ohio

My commission expires May 22, 1989.