#594

THE STATE of OHIO, :
: SS:
COUNTY of CUYAHOGA. :

IN THE COURT OF COMMON PLEAS

ARAZINE SMITH, executrix of the ESTATE of CAROLYN YARBOROUGH, plaintiff,

vs. : Case No. 326850

SAINT LUKE'S HOSPITAL, et al., defendants.

Telephonic deposition of DONALD E. FREY, M.D., a witness herein, called by the plaintiff for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Constance Campbell, a Notary Public within and for the State of Ohio, at Reminger & Reminger, 113 Saint Clair Building, Cleveland, Ohio, on THURSDAY, JULY 9TH, 1998, commencing at 12:36 p.m. pursuant to agreement of counsel.

APPEARANCES:

ON BEHALF OF THE PLAINTIFF:

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I N D E X

WITNESS: DONALD E. FREY, M.D.

(NO EXHIBITS MARKED)

(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

DONALD E. FREY, M.D.

of lawful age, a witness herein, called by the plaintiff for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, being first duly sworn, as hereinafter certified, was examined and testified as follows:

MISS KOLIS: Good afternoon, Dr. Frey, it's Donna Kolis.

THE WITNESS: How are you?

MISS KOLIS: I'm fine. How about yourself?

THE WITNESS: Staying busy.

MISS KOLIS: I would imagine. Are you sitting in the rocking chair or the other side of the desk?

THE WITNESS: On the other side of the desk.

MISS KOLIS': That's good.

THE WITNESS: The rocking chair is too far removed from the telephone.

MISS KOLIS: I'm probably going to shock you, not ask a tremendously large number of questions today.

THE WITNESS: Okay.

MISS KOLIS: However, to each and every question that I ask you, if you need clarification as to what information I'm seeking, as always please tell me, okay?

THE WITNESS: Okay.

CROSS-EXAMINATION

BY MISS KOLIS:

Q. We are not going through your CV because you and I have been through your CV before, correct?

A. That's correct.

Q. I have in my possession a report authored by yourself, I would recognize the signature, dated June 10, 1998; do you have a copy of your report available?

A. I have it right here before me.

Q. I can assume without even asking the question that this is the one and only report you've ever written?

A. That is correct,

Q. Doctor, can you tell me when Mr. Goldwasser contacted you?

A. He contacted me by telephone some time towards the end of February of this year, Gave me some telephone details about the case, asked if I

would be willing to review it for him.
Q. Fair enough. Have you done any testifying for Mr. Goldwasser before?
A. I'm not sure if I have testified for him or against him. I have met him in a previous proceeding. At this point I'm not sure I can remember specifically what role the two of us were playing.
MR. GOLDWASSER: As an aside, Eric Kennedy retained you.
THE WITNESS: Yes.
MR. GOLDWASSER: I had the wonderful task of trying to cross-examine you at trial and I did not succeed.
THE WITNESS: I'm sorry to hear that.
MR. GOLDWASSER: That's all right.
Q. It does happen however. I knew you had appeared as an expert in a case where Gary was defense counsel, I didn't know if you worked with him before.
A. I honestly can't remember. I met Mr. Goldwasser previously.
Q. Obviously all that is very unimportant.

For purposes of the record, anyone who might read it in the future, it's fair to say, Dr. Frey, from time to time you are called upon both by plaintiffs and defendants to render testimony?

A. That is correct.

Q. It's fair to say that as things in life, your testimony is not always accepted by the jury?

A. I'm sure that is true.

Q. Now that we have all that out of the way, what we're going to do is talk about this case.

The report indicates that you reviewed eight items in contemplation apparently of preparing your report; do you see that?

A. That's correct.

Q. Since the time you authored this report on June 10th have you received any additional material?

A. I have received -- I believe I have received the deposition of Dr. Holzman, I've minimally gone over it to see if it was going to be the same -- whether it was going to offer up the opinions he offered in his previous letter. I would not say I have exhaustively reviewed it. I previously reviewed it.

Q. In fairness to characterize, if you actually have Dr. Holzman's deposition, you would have gotten it yesterday afternoon; does that seem reasonable to you?
A. I received so many depositions I have no idea. Mr. Goldwasser and I reviewed the deposition by telephone here just earlier today.
Q. Dr. Frey, have you looked at any other medical records?
A. I have only looked at the medical records that were identified in the report of June the 10th.
Q. So you haven't looked at the Candlewood Nursing Home records?
A. I have not.
Q. You don't have any of the documentation showing Mrs. Yarborough's history leading up to her care by Saint Luke's, you haven't seen the Cleveland Clinic chart or Metro General chart from the Fall of 1995?
A. The only information about those hospitalizations would have been from entries in the Saint Luke's record that referred back to them, so I have not seen the records themselves.
Q. I wondered. During the process of this case

we obtained a lot of those, I didn't know if you read them or felt you needed to?

A. I have not reviewed those records at all. Those were not provided for me, nor did Mr. Goldwasser fax to me any elements of those.

Q. What I'm going to try to do is find out what you really think about this case. That is a good. thing for me to do I suppose.

Let me ask the first question: Let's first deal with what you believe, based on your best medical judgment or opinion, is the cause of Mrs. Yarborough's death; can you state that for me with simplicity if it's possible?

A. I think she clearly died of fulminant sepsis and septic shock.

Q. Let's sort of dissect that out a little bit.

When I read your report, in the report you indicated that autopsy demonstrated that the patient died of intra-abdominal sepsis -- I mean abscess. Excuse me.

Do you still agree that is what the autopsy most likely demonstrated?

A. I would agree with that.

Q. Do you have an opinion which you intend to be rendering at trial as to the cause of the

intra-abdominal abscess?

A. The cause of the intra-abdominal abscess was clearly in my view contamination from the perforation for which she was operated on January 10th.

Q. Let me ask you this question: Do you have the autopsy in front of you?

A. I do.

Q. Somewhere on that table?

A. It's right here,

Q. The question is, there are two of them I need at least some clarification on: There was a finding on the autopsy of transmural ischemia of the jejunum?

A. Yes.

Q. Would you agree with me more likely than not the ischemia found in the jejunum would not have been the cause of the abscess found in the abdomen?

A. I would agree with that.

Q. Thank you very much.

In the Huron Road Hospital record there is a positive, I'll call it highly positive urine culture in Carolyn Yarborough.

Would you agree UTI that seemed to demonstrate was not the cause of her death?

A. Are you specifically refering to the Candida urine culture?

Q. No, I think I just made myself not specific.

A. I do not consider urinary tract infection to be the cause of this patient's death.

Q. You just made this very easy for me. That eliminates a majority of the questions I would have needed to ask on that issue.

I don't know that you and I are going to go through every hospital note, let's see what we can do with this.

Your contention of course is these physicians, and those physicians being Drs. Sonpal and Bass, did not deviate from what you consider to be the standard of care; am I stating that accurately?

A. That is correct.

Q. We will get into the specifics later. You conclude, I'll read it for the record, "This unfortunate patient died of severe immunosuppression from her underlying illness and steroid therapy;" did I read that statement accurately?

A. That is correct.

Q. Try to explain to me what you meant when you

wrote that statement.

A. That when patients die of sepsis, they can die of sepsis, if you will, for two reasons.

Number one, they can die because the volume and the virulence of the microorganisms with which they were infected overwhelms their host defenses; or they die from quantities of bacteria that might have otherwise been adequately managed by a competent host, but because of the individual's immunosuppression status the microorganisms were able to cause a systemic septic response and death.

Q. Mrs. Yarborough's case, which of those two possibilities or not possibilities, which of those two events was the cause of her sepsis?

A. It would be my opinion that her immunosuppressed state materially contributed to her inability to eradicate the residual microorganisms that were not killed or handled by the antibiotic therapy.

Q. You're distinguishing that from a person who has a volume and virulence overwhelming the host?

A. Correct. If we take the analogy of an otherwise very healthy 20 year old that would have a very large perforation, if you will, of an

appendix, that was then not managed, there was continuous and sustained stool contamination of the abdominal cavity, you would then have a circumstance where the volume of the microbes and the invasive infectious capability of those microbes would overwhelm the capabilities of what would have otherwise been a normal host.

Q. Thank you very much for that answer.

Based upon the autopsy result and/or Huron Road records, whichever you need to answer the question, the intra-abdominal abscess, abscesses as best you can determine from the autopsy, were caused by what? Let me rephrase that, that was a poorly asked question.

We already established you believe the abscesses developed as a result of the original contamination which occurred at the time of the perforation. Tell me based upon your review of the medical records what the components if you will of the abscess were?

A. The abscess as identified on the face sheet identifies the pathogen as being principally that of Candida. That is to say if we look at the very final diagnosis, it's identified as anteroposterior subdiaphragmatic abscess containing organisms

consistent with Candida species.
Q. I think in your report you indicated the abscess also had a component of Enterococcus?
A. The abscess, the original culture of the peritoneum had Enterococcus and Enterococcus was identified from --
Q. The blood stream?
A. -- the blood cultures that were done at the time of the postmortem, so one would have to conclude that the Enterococcus was likely a participant in some capacity in this patient's terminal event.
Q. You're inferring that based on the reason you've given that was an organism identified by culture at the time of the original contamination and it actually had gone into the blood stream by the time of death, correct?
A. She had the organism cultured in her blood stream at the time of her death, we have to conclude that it was a participant in her terminal process.
Q. That's fair enough. I just want to know how you respond to that.
A. I understand. I want to make it clear that it may or may not have been the same strain of

microorganism that was cultured from the original culture at the time of the original operation.

Q. When you say it may or may not have been the same strain, are you referring to the Enterococcus?

A. That's correct.

Q. Have you compared the sensitivity to the blood culture at Huron Road Hospital to the sensitivity of the Enterococcus cultured at the time of the surgery?

A. I have not.

Q. Let's do it this way: You could do that?

Let me ask you generally speaking Doctor, do you agree with me we can pretty much tell if something is the same strain by looking at its sensitivities, its resistance and its synergistic abilities?

A. That would imply similarity or dissimilarity. It might not stand up in a court of law.

Let me amplify that very, very different strains of Enterococcus could have the same sensitivity pattern and genetic analysis would show that they are clearly different.

Similarly an organism that was similarly isolated at the time of the peritoneal

culture which may have mutated or developed resistance during the course of the patient's treatment, could actually potentially demonstrate a different sensitivity and resistance pattern some 15, 16 days later, in fact still be the same strain.

In general I would agree with what you are implying. Please understand that there would be a perfectly logical argument that would say that it may not be certainly a 100 percent accurate statement to make that linear correlation.

Q. Is it more likely than not it's the same?

A. Probably.

Q. That's what I need to know.

Doctor, let me ask you this question: Given that you just now testified that in fact it's the intra-abdominal abscesses that precipitated in I assume you believe the events that led to this woman's death, can you explain to us why the hospital didn't find Candida in the blood stream?

A. First of all if one reads the literature on Candida you will find that recovering the Candida from the blood stream can be difficult in that Candida is sometimes an episodic organism in the

blood. In some respects there are random chances involved in identifying the organisms in the blood or not.

Secondly, because one dies of sepsis from an organism does not necessarily mean that the organism had to be in the blood.

That is to say there is a fairly wealthy volume of literature that would clearly identify that what we call clinical sepsis relates to the various mediators of inflammation and that one can have sepsis independent of really having the organism in the blood or not. So I think there is a couple of very plausible explanations why one could potentially die from a severe Candida infection and in fact not have the microorganism in the blood.

Q. What you describe, if I can characterize, is a differentiation I think which causes confusion to lay people, particularly lawyers, the difference between sepsis and septicemia, the organism actually being in the blood. Sepsis describes a physical state of being.

A. Actually you know you are getting into the issue of terminology which is very confusing for physicians and I would guess it's equally confusing

for lawyers. Sepsis and septicemia are sort of used as interchangeable terms. We are referring to a clinical state that is due to infection but neither sepsis nor septicemia in fact have to have the organism documented or present in the blood to establish that as a clinical diagnosis.

Q. Fair enough.

A. Sepsis is a clinical state, bacteremia or fungicemia is the process of recovering the organism from blood and the two are commonly associated but they don't have to be.

Q. Thanks for clarifying that issue for us.

Dr. Frey, you are aware that on January 14th, 1996, that the results of the intra-abdominal wound cultures came back; does that seem accurate to you?

A. That is correct.

Q. It indicated in that culture result that there were Enterococcus and Candida, right?

A. On the surface culture of the open wound, that's correct.

Q. Let me ask you this question: Based upon your training and background in managing surgical patients who have perforated, would there have been a contraindication at that time to initiating

antifungal therapy?

Ae It would have been outside of the standard of care to have initiated antifungal therapy at that time.

Q. Why do you say that?

A. Because you are talking about colonization with no clinical evidence the patient in fact had Candida as a participating microorganism. So even the most liberal person in using antifungal therapy would not institute antifungal therapy based on the surface culture of an otherwise clinically uninfected wound.

Q. That's your position in this case that is why there is no deviation as to the standard of care, at least as to that issue?

Ae There is no question in my mind that is the standard of care and that if one uses surface cultures of open wounds as a justification for antibiotics, every patient with an open wound would be on antibiotics. So one has to make the clinical differentiation of what is surface colonization versus what represents a clinically relevant pathogen.

Q. Clear this up for me so I understand what you are thinking.

A. You are calling the return of the cultures surface cultures; is that accurate?
A. On the wound, cultures of the 14th.
Q. Not the results that came back on the 14th?
A. The results that came back on the 14th, of course those are from the peritoneal cultures, different than the wound.
Q. It could have, as everything else in this case, been the problem with the person that asked the question.

I was referring to the cultures that came back from the peritoneum itself,

A. Okay.
Q. Those grew Candida and Enterococcus, correct?
A, That is correct.
Q. Having said that, we're asking a different question: Would there have been a contraindication based upon the cultures that grew from the peritoneal area to instituting antifungal therapy in this patient?
A. Contraindication, that is a pretty strong term. I would say it's clearly not the standard of care to implement antifungal antibiotics for a patient who had Candida identified in the initial peritoneal swab four days later without there being

some additional evidence of Candida's involvement in the patient's infectious state.

Q. So you are saying it's not the standard of care to initiate antifungal?

A. That is correct.

Q. Would you answer the question any differently, Doctor, if I added to that that the person was known to be immunosuppressed from taking corticosteroids?

A. It would still be the same answer.

Q. I'm going to deviate from what I thought I was going to ask you and ask you a couple other questions looking at textbooks do you have a copy of your textbook?

A. There are one or two of them here.

Q. I would guess there would be.

If I heard you correctly, your answer was that it was clearly not the standard of care to initiate antifungal therapy for Candida which grows out of peritoneal cultures in the absence of some sign that there was an infection; I did hear you right when you said that, let me clarify.

A. I would refer you to our article in the Annals of Surgery in 1991, that has as a first

author Dr. Mosdell, M-o-s-d-e-1-1. In that article you will find if you review those 480 patients with acute peritonitis that a number of them, in fact if my memory serves me correct, somewhere around 5 or 6 percent of the patients had Candida identified on the initial culture of the peritoneal cavity.

If one looks at the outcome in those patients, you will find first of all none of them received antifungal therapy. That secondly their survival as a group was no different than the population as a whole.

So it would be my very considered opinion that there is no justification for adding antifungal therapy in the initial treatment of a patient with acute bacterial peritonitis.

Q. Let me back up. The Mosdell study of 480 patients, that didn't specifically address itself to immunosuppressed patients, do you agree with that?

A. I would agree with that.

Q. So the 5 to 6 percent population group we were looking at, that had no adverse Candidal illness I'll call it, I don't think that's a real phrase, were not immunosuppressed patients?

A. For the most part that would be true.

Q. Let's move this a little bit.
A. There is still not a shred of evidence that shows in immunosuppressed patients that empirical antifungal therapy would make any difference in the patient's outcome. I would continue to hold steadfastly to the position there is no justification for the addition of antifungal therapy in a patient with an acute intestine perforation, even though that person is on immunosuppressive treatment.
Q. We're going to look at a couple pieces of literature, see if you can tell me what they mean I suppose. Let me go back to what you said.
You said there is empiric evidence that the initiation of antifungal therapy will change the outcome, I was trying to listen to you, I don't think I was clear about what you said, that it's effective?
A. That's not what I said.
Q. Tell me what you said, I really did miss it.
A. Antifungal therapy for patients that have positive blood cultures for Candida would generally be considered a standard of care.
If you had patients that were reoperated after acute bacterial peritonitis, those

patients at the time of reoperation were identified as having Candida peritonitis at that time, then there would be certainly a body of evidence to support the implementation of anti-Candida therapy,

There is no evidence to support the initiation of antifungal therapy in the initial management of patients with perforations and acute peritonitis.

Q. Let me ask you the following questions, I know for sure we're going to look at your literature, that which you edited: Do you believe or agree with me medically that steroids have an effect on potential growth of Candida in the GI tract?

A. I would not agree with that.

Q. You don't think there is anything published that says that?

A, I would say what is published indicates that steroids promote Candidemia, it's antibiotics that change the micro flora.

I do not believe that steroids in and of themselves in a patient without antecedent antibiotic therapy results in Candida overgrowth in the gut.

So they are commonly linked together. I would certainly agree that corticosteroid therapy is associated with Candidemia. If you look at the various articles that have been written on it, the patients invariably have had antecedent antibiotics which eliminated the bacterial component in the gut.

Q. You answered the question I was going to make a two step question, which you just explained, which is my understanding if a person is on steroids, received a course of antibiotics, that they will -- I'm paraphrasing -- create an environment for overgrowth of Candida which can lead to infection with a Candida organism, that's the simple way of stating it?

A. That's pretty close. I think the antibiotics create the potential Candida overgrowth. The steroids inhibit the host's ability to contain the Candida organisms.

Q. Do you agree with me as a simple matter, I understand there is no such thing as a simple matter in this kind of treatment, that what happens is the traditional antibiotic regimen such as Cefotetan, Gentamycin and Flagyl inhibits the bacteria that usually take precedence over Candida

in the gut; do you agree with that?
A. Run that one by me again, please.
Q. I'm making up the questions based on everything I read in two weeks. I think we're saying the same thing, I want to make sure I'm understanding the mechanism what allows the Candida to grow in an immunosuppressed person taking steroids is the antibiotic regimen more or less kills the normal bacteria that Candida compete with; does that make sense the way I'm saying it?
A. I think that is very accurate. I think predominance of the Candida microorganisms in the gut is more a consequence of eliminating the bacteria which competitively suppress Candida under normal circumstances, so I would agree with you completely that the growth of Candida is the consequence of bacterial suppression. That the Candida then assumes some greater significance in potentially immunosuppressed patients because of their immunosuppression.
Q. Right, because as a general principle I don't know if you agree or disagree with this, a person who had a perforation such as Mrs. Yarborough did, who was not immunosuppressed, they received the Gentamycin, Flagyl and Cefotetan, we would not be

very concerned about them having a Candida overgrowth?
A. I don't think that is correct at all.
Q. Okay, tell me what you think then.
A. I think if you have 10 days of those antibiotics, you have a real chance of having Candida overgrowth. It probably happens in the majority of patients that would receive that. Just because the patient has steroids, they realistically have a greater risk of Candida being clinically significant than with somebody who has an intact immune response.
Q. We were saying the same thing, you say it more articulately. The person who is not immunosuppressed is not likely to have a clinically significant event occur because of Candida growing, not as likely I suppose is a better way to put it?
A. I think that's fair to say.
Q. Do you agree or disagree with Dr. Bass' testimony that through the course of Mrs. Yarborough's hospitalization, that she demonstrated postoperative fever?
A. She did demonstrate postoperative fever.
Q. Would you say that it was a low grade postop fever?

A. It was low grade much of the time. I guess low grade depends on your perspective of it. Some of it was if I remember above 38 degrees Centigrade, which some would consider a higher grade than others. She clearly had a waxing and waning fever pattern postoperatively.

MR. GOLDWASSER: Doctor, let me correct you, I think only one day following her initial insult was it 38.

A. I do remember that it was above 38 at one time.

Just for purposes of clarification in this deposition, in case we argue about what low grade means, I did want to indicate there was an over 38 degree event. That the temperature for the most part sort of waxed and waned in the 37 plus range.

Q. I don't want to have an argument at trial if that is where this goes on this issue, What I'm trying to indicate, we will make it simple, if I can do such a thing ever, is that she did not have a stable, normalized temperature during her confinement from January 9th through January 24th; would you agree with that?

A. Well I guess it depends what you call

normal. I would say it was pretty normal fever curve for a convalescing patient from peritonitis. To say she was stone cold 37 degrees, she was not.

Q. No, She did have a persistent fever, although it fluctuated, she did persist with fevers?

A. She had low grade fever.

Q. Fair enough.

In general, one of the participants in this case whose been identified on the side of the defense has indicated that in his medical opinion steroids are the most powerful antipyretic that exists; do you agree with that statement?

A. Maybe not most. I would be reluctant to say most powerful. I would agree.

Q. He might not have used the word most,

A. Corticosteroids are known to suppress the fever response.

Q. They are he said a powerful antipyretic.

A. I would generally agree with that.

Q. Doctor, do you infer, I'm just asking what you infer as a doctor, if you were looking at these fevers, since Mrs. Yarborough was on corticosteroids, was able to mount fevers, without them the fevers could have been higher?

A. That is a potential conclusion.
Q. Is there some other conclusion?
A. I think that whether a patient is on steroids or not, the fever needs to be evaluated in the overall light of how the patient is doing.
So I think it is not unreasonable to conclude that the temperatures may have been higher had she not been on steroids.
Q. Because the steroids would -- I use the word repress a lot because I don't understand steroids quite as well as I probably should. I guess the import of what I'm saying is if the body is trying to mount an afebrile response to an initiator in the body, whether it's trauma or infection, the steroids repress to some degree that inflammatory response; do you agree with that?
A. In many patients they do, in some others they don't. In general we recognize steroids as suppressing the fever response.
Q. In this patient, we've already established you believe she was immunosuppressed?
A. I think from the magnitude of the steroids that she was receiving, I think it would be fair to say she was immunosuppressed.
Q. A couple other points about the effect of

steroids.

Do you agree that steroids in the quantity, however declining it was that Mrs. Yarborough received, would also inhibit the body's ability to respond to your classic abdominal finding of rigid abdomen, things of that nature that might be indicative of a brewing infection?

A. It would potentially modify the response because steroids modify the inflammatory response, it would clearly be a potential modifier of the physical findings that one might customarily see.

Q. Doctor, I'm going to ask if you don't mind to pull out your textbook for a second.

A. Just a second.

Q. This textbook has got your name on the front, that means it's your textbook, you are the editor, correct?

A. That is correct,

Q. Every article that has found its way into this textbook had to be approved by yourself?

A. It would mean that I would have edited and reviewed it.

Q. If someone put blatantly wrong information in an article, can I suspect you would have removed it from the article or chosen not to put it in your

book?

A. Blatantly wrong I would have edited it out.

Q. I'm being facetious. I assume that is the process, I know it took years to put this book together.

I would like to turn to page 69, the chapter by R. Lawrence Reed, II.

A. Okay.

Q. Nice general discussion for surgeons about the activity of antibiotics. I would like you to look in the section on antifungal agents.

A. All right.

Q. Second column at the bottom, actually I'm going to read the whole section, you can discuss it, tell me how I'm misinterpreting this.

It says that fungal infections are being observed more frequently in the surgical patients one to two weeks after having prolonged parenteral hyperalimentation who received broad spectrum antibiotic coverage, that had some violation of alimentary tract integrity, correct?

A. That's correct.

Q. That's what you and I just discussed, broad spectrum antibiotics causing shall we say the existence of more fungal infections.

Says the diagnosis is sometimes difficult to make because luxuriant Candida growth may represent merely colonization, not invasive infection?

A. I think we've been saying that too.

Q. It goes on to talk about further complications. The problem is the potential toxicity seen with Amphotericin B traditionally used for severe fungal infections -- you are reading along with me, right?

A. Yes.

Q. Because of this, therapy for fungal infection is generally withheld until the diagnosis is confirmed with tissue biopsy or positive blood culture, You refer to in a situation such as a positive blood culture it's a must do; however, there are frequently patients that fail to receive appropriate therapy because the diagnosis was not made until the autopsy was performed.

That harkens back to what you and I already discussed, Candida doesn't, for some reason unknown to us, just doesn't always present in the blood, correct, it intermittently can?

A. Correct.

Q. We're still together on this.

It says it is generally advocated therefore an aggressive attitude be taken; do you agree with the statement in this article?

A. Generally I would.

Q. Skipping to where it talks about what dosage of Amphotericin B, then says thus granulocytopenic patients, this was not one, or other severely immunocompromised hosts with persistent fever, after one week of antibiotic therapy, should receive Amphotericin B therapy, despite the absence of microbiologic confirmation; do you agree with that statement as written by Dr. Reed?

A. I think it is a controversial statement, not blatantly wrong. The introduction to this series of questions would I edit something out that was blatantly wrong, I would say there would be a substantial split in vote. Most of us appreciate the fact that the diagnosis of Candida to be extraordinarily difficult, but he does say granulocytopenic patients, which this patient was not.

Q. Correct.

A. Persistent fever gets into the debate about what defines a persistent fever. While we may say there was a smoldering fever in this patient, who I

might add had an open abdominal wound which would cause fever, I would generally agree with the flavor of Dr. Reed's comment, would obviously make the proviso that there are no absolutes. That clinical judgment is in order. That I would not for a second have advocated antifungal therapy for this patient.

I would also point out to you he's talking about after one week of antibiotic therapy, the cultures that you are referring to are in fact the cultures that were obtained at the time of the operation, before the patient had received any drug therapy.

Knowing Dr. Reed very well, I would be confident that he would have not advocated antifungal therapy for this patient. You might even choose to call him and ask him.

Q. I don't know if I have time to recruit him as an expert. I might call him some day and ask him at your request.

A. You might call him, he's a terrific person.

Q. Isn't the issue in this case that a culture was grown from the peritoneal cavity that contained two organisms, Candida and Enterococcus, that in a person who was not immunosuppressed you might not

ever change the therapy to address those cultures; you agree with that?

A. That is correct.

Q. I think that you appreciate obviously based on reading the reports, you haven't had an opportunity to talk to me about it, my contention is in a person such as Mrs. Yarborough it's absolutely foreseeable she is at risk to develop ill effects of Candida that you already indicated may not show up in the blood until after the fact; do you agree with that, she was at risk to develop an infection from Candida?

A. She was at risk,

Q. That is a foreseeable series of events?

A. That was a possible outcome, not foreseeable.

Q. When I use the word foreseeable I was not using it in the legal sense of the word. If you are a doctor, someone says to you here is an immunosuppressed patient, she has had massive fecal contamination due to perforation, there is what we grew out of the culture, you know what the antibiotics are. Isn't it a fair medical conclusion to draw at that point that you will have a concern that the person may become infected from

the Candida because of their circumstances?
A. I think that it is a fair medical concern that Candida would be an issue for this patient.
Q. Skipping to the chart itself, this may be the only chart question I ask you today.
Have you had an opportunity to review the progress notes that are included in the chart from the day that the positive cultures came back? We can turn to it if you would like to.
A. Why don't you tell me which ones you are referring to so I don't have to guess.
Q. I wouldn't want you to guess. We will flip to it.
MISS KOLIS: Gary, I don't know, did you send him a Bates stamped copy?
MR. GOLDWASSER: I did not.
MISS KOLIS: We're going to have just a little trouble. Not much.
MR. GOLDWASSER: Doctor, I should have sent you a chart which has tabs in it,
THE WITNESS: It has tabs. I have the progress notes before me.
Q. If you would flip to the 14th, the 14th of January.
MR. GOLDWASSER: There are two

entries for that day.
Q. The first entry I would like to look at is on the bottom half of the page, the notes of the 13th, POD 3 starts at the top.
A. I got it.
Q. That is the date obviously when we see these recorded in the chart, correct?
A. That's correct.
Q. I want to ask you this question: Based upon progress notes alone, no other extraneous material, from the 14th to the date after this lady's discharge do you see any concern or discussion in the medical chart itself about this woman potentially being infected with Candida?
A. On the 14th they identify the culture results, I try not to memorize these, so I'm having to read through it all again.
Q. I'd be more than happy to pay you for the time it takes you to read them today, that is fine.
A. Yeah, there was the concern about having a positive urine culture which was on the 22nd. That a culture of the wound as it was indicated here grew a Candida and Enterococcus, and that led to the infectious disease consult.

Q. Let me ask you this question a different way: First of all, I know I'm going to know the answer, I would like to ask it. You aren't advocating the elimination of the subspecialty of infectious disease? I'm not talking about this case, in general?

A. Certainly not.

Q. Certainly not. You've written the book Surgical Infections to better educate surgeons what exists out there; would you agree with that?

A. Yes. I would hope that it would have some value to infectious disease specialists as well since many of them have a more limited exposure to surgical based infections than they might otherwise. Since they get consulted, that I hope this book might serve as some value to clinicians who were infectious disease specialists as well as surgeons.

Q. My question is this: Do you or do you not call in infectious disease doctors when you receive cultures with these organisms in them from the peritoneal cavity?

A. I would myself almost never call in an infectious disease person for this kind of situation.

Q I would expect that would be true.

There is no standard of practice that you are aware of that requires a surgeon to bring in an infectious disease person to help interpret treatment for cultures, is there?

A. In this situation, I would not consider it as standard of care to have an infectious disease consultant.

Q. You would expect that the general surgeon who was caring for this patient would have enough medical knowledge to understand and interpret the event and issues surrounding an immunosuppressed patient?

A. I would generally expect that he would but I wouldn't fault him if he wanted his impressions and feelings confirmed by someone else.

Q. You've read the depositions of Dr. Bass and Dr. Sonpal?

A. Yes.

Q. What do you interpret the testimony of Dr. Bass to be as to what his understanding was for the purpose of his consult on the 23rd?

A. You know you are asking me now how much can I remember, so I would have to refer specifically to the deposition itself.

Q. I'm going to withdraw that question.

Let me ask you this: Is part of the way you reasoned this case based on the fact that Dr. Bass, if he testified to this, testified that he was called in for the limited purpose of looking at the results of the wound cultures that occurred later in the hospital course.

MR. GOLDWASSER: Donna, excuse me, he did testify to that. He also testified that he reviewed the patient's entire course before writing his progress note.

Q. Mr. Goldwasser will be able to ask you that.

I'm asking if he testified that it was his understanding his purpose was to evaluate solely the culture that subsequently grew out of the wound, is that how you worked out whether or not someone deviated from the standard of care?

A. Independent from the deviation of the standard of care issue it would be my understanding as I'm looking through Dr. Bass' deposition and with your comments he does suggest that he was consulted for the reason of evaluating the wound cultures. 1 would expect generally that an infectious disease person, in a patient like this, should be at liberty to make whatever

recommendation he or she thought was appropriate in the patient's overall care relative to infection.

Q. Fair enough answer.

Doctor, have you seen the CTs?

A. I have not.

Q. Let me ask you a question about CTs and your ability to look at them. I gather that you read -- skip what you read.

Do you in your surgical practice look at the CTs when you have ordered them for the purpose of looking for an abscess?

A. I almost always do.

Q. Let me ask the question this way, I don't know if there is a good or easy way to ask the question: Don't you look at them because through the years you've developed an eye for ferreting out what may be a sign of infection on a film?

A. I've looked at lots of them so I like to look at suspicious things. Potentially if there is something that I see that is troublesome that may not have been addressed by the radiologist in his or her formal report, we would have an opportunity to discuss it.

Q. Just as a general matter to establish this line of thinking I suppose, it's not that you are

being disrespectful to the radiologist, it's that you acknowledge that radiologists read lots of different kinds of films; would you agree with that?

A. I would generally agree with that.

Q. Because this is something you deal with, you may have a better grasp what something looks like on a CT film, right, as a general principle?

A. I think that relative to abdominal abscess that I can give a radiologist a pretty good run for his money on identifying whether a patient has an abscess or not. Since I have seen probably as many abdominal abscesses on CT as any living person, I don't think the radiologist would be offended if I chose to ask about a specific.

Then of course the only thing that is always a problem, that when we order CTs we probably don't give the radiologist enough of a history about what may have transpired in the patient's care leading up to the CT. So sometimes I think it's very useful for the surgeon and the radiologist to go over the CT together.

Q. Along those lines, when you say you don't give them enough history, I guess what you -- not that you said you don't give them enough history,

sometimes they don't have enough history?
A. Sometimes in the hassle of life we don't write down on the consult the pertinent things that would necessarily help the radiologist, so it's certainly been my observation that a patient like this may well have written on the consult rule out abdominal abscess without necessarily identifying for the benefit of the radiologist that the patient had a perforated viscus 10 days previously so on and so forth, giving them a little more help. Sometimes after the scan is completed it's I think beneficial for the surgeon and a radiologist to go over the films together.
Q. Doctor, do you have an opinion based upon the course of events that occurred in this patient as to whether or not on the day she was CAT scanned, I'm stating that it's January 20th.
MISS KOLIS: Am I right, Mr. Goldwasser?
MR. GOLDWASSER: That's right.
Doctor, as an aside before trial you'll have a chance to look at the film itself but go ahead.
Q. Do you have an opinion as to whether or not the abscess was present on January 20th?

A My suspicion is that it is unlikely that the abscess formed completely from scratch if you will between the 20th and the time that the patient died. So I would say there was clearly at the least incipient abscess that was present on the 20th, but was just outside of the resolution of the CAT scan to identify.

Q. Right. I was wondering if that would be your answer. To put it in layman's terms so you and I can talk about it at trial, you do have an opinion it had to at least as you state be in its incipient form on the 20th?

A. That is correct. I think despite all of our perception of CAT scan technology, there is still a definable false negative or false positive rate for the abscess when one scans the abdomen.

Q. Or sometimes the radiologist taking as many cuts as he thinks he should, lines it up on the Scout film, we're doing 16 levels, sometimes you need a little closer level?

A. Perhaps I think in fairness to everybody when there is an anatomic distortion from inflammation, peritonitis, operation and so forth, one doesn't always -- the anatomic resolution just isn't as good as we might like. So arguing that maybe too

few or that not enough cuts were taken is a possibility.

Q. Except that when I am discussing this, it's just to establish a principle, I'm not criticizing the radiologist.

A. I'm not interpreting what you are going in that direction.

I'm also just saying that understanding the natural history of abscess formation, with surrounding inflammation and loops of intestine being in and around the process, that it is perfectly understandable to me that one may have -- I believe I've written this down, a 10 percent or so risk of a false negative abdominal CT scan.

Q. That is what you wrote down, I agree with that.

Would you expect that a surgeon who does abdominal surgery would understand that a CAT scan is not a 100 percent fail safe in the detection of an abscess, I should use that phrase?

A. I think that most surgeons would appreciate it is not a totally foolproof enterprise. I would generally think that most surgeons would recognize that.

Q. I'm going to read you a sentence, I'll tell you it's out of your lovely chapter on peritonitis, page 229. If you want to turn there, you know I wouldn't misread it on purpose, I'll read it into the record. "While the physical examination is of enormous value in establishing a diagnosis of acute peritonitis, it's often of limited value in a postoperative patient in whom abdominal abscess is suspected;" do you see where you wrote that?

A. That sure sounds like me.

Q. It does sound like you. To clarify for me so I understand that assertion correctly, are you stating in pretty simple English in the postop patient if we were worried about something lurking that is going to cause an abscess, correct, we're not going to have a real easy time palpating or finding in the regular person, finding that abscess in the face of abdominal wall incision; do you agree with that in general?

A. Doing a physical exam, a manual physical exam in someone who has a recent abdominal incision will show all of those patients having equal degrees of pain and discomfort, so there is no discriminating value in my opinion to the physical exam in a patient that's had a recent abdominal operation for

peritonitis or anything else.

Q. I agree with you. Let me talk to you about something else you've written in your article in your book,

Almost all the peritonitis patients you will see a leukocytosis shift on differential examination to more immature neutrophil forms; you agree that is probably something you wrote?

A. Yes.

Q. Same page.

Have you seen leukopenia with a shift being indicative of infection in any situation?

A. I think you can. I think you can see patients that have profound fulminant sepsis end up having for whatever reason -- I could actually explain it, this may not be the time or the place they develop a leukopenia, a low white count.

The white cells that are mature are all gravitating to the site of the infection. So when one samples the blood, you find an overall low white count, but because the mature forms have gone to the site where they are supposed to be, you will see a relative increase in the number of immature forms.

Q. Have you been -- I'm going to try to ask a question here: Would you agree that a band of 10 is indicative of a left shift or could be?

A. A band count of 10 is probably a modest left shift shall we say.

Q. Let me ask you the question a different way. If you have a trend toward a shift let's say January 20th it's 1; January 21st, 2; January 23rd it's 5; January 24th it's 7; January 25th it's 10; do you see that as a trend toward a left shift indicative of the body's need to respond to inflammation or injury?

A. It may or may not. It depends on whether the overall white blood count was declining or rising because one of the things you have is if the overall white count is declining, what you are seeing is a preponderance of immature forms simply because the mature forms are leaving the circulation for whatever reason. I would not argue that a band count of 5 to 10 would reflect some influence of potentially ongoing mild inflammation,

Q. Let me ask you this, Doctor: Since you and I already established that in your honest medical opinion in looking at the totality of the

circumstances that at least on January 20th or at least by that time when the CAT scan was taken there were the probably incipient beginnings of abscess in Carolyn, are you aware that there was a trend in the left shift, have you been made aware of that?

A, Yes, I'm aware of that.

Q. Would you say that trend in the left shift, now that we both can agree obviously this abscess had to be forming at that time, was in response to the response to the abscess being formed in the abdomen?

A. It may or may not have been. I would just emphasize that patients that have open wounds have reasons to have some element of a left shift by itself, so I think in retrospect one could make the conclusion that you're making, I think it's a pretty big reach to say that every patient that has a modest left shift has an incipient Candida abscess in the abdomen,

Q. We're not talking about any patient. I'm asking if this clinical data doesn't make sense to you in light of what we already know about this patient?

A. In retrospect that you can make that

statement that may have been a piece of evidence that may have supported the ultimate diagnosis.

Q. I hate asking you these silly lawyer questions but I have to do it, you know that: Do you agree with me -- let's talk about the fact that the peritoneum was -- peritoneal cavity was cultured.

Someone, I think Dr. Lerner in his report, I suspect I may hear it on video, said it's not the standard of care to culture abdominal wounds; do you agree with that?

A. I agree with that.

Q. Do you agree with me however if you do culture those, you learn the results, that your knowledge now places you in a position of responsibility?

MR. GOLDWASSER: Responsibility for what?

Q. In other words it isn't a defense to fail to act on a culture -- I'm not leading you to try to get you to say anybody was responsible. You are not going to say that. You can't sit there and say we didn't have to do it anyway, the fact we knew what was on the culture doesn't make any difference; does that make sense to you?

MR. GOLDWASSER: Do you understand the question?

A. No, I really don't. I don't know if you are talking about the wound culture or peritoneal culture.

Q. Talking strictly the peritoneal culture?

A" I think that if you have some information before you, it's always good to know what the information is. I think if the surgeon chooses to do the culture, whether the culture is a standard of care or not, if you do the culture you should probably know what the results are.

Q. That is all I was trying to establish.

Doctor, further in your chapter on peritonitis you say you and your colleagues, I'm not sure who they were at that time, page 233 to 234, where you summarized essentially it looks like to me an investigation that you and your colleagues did from major hospitals in urban communities, talking about standard of practice employed in clinical circumstances, I want to ask you a couple of questions in case you bring this up at trial.

You concluded that not everybody does cultures and they don't necessarily have to do them is a nice easy way to state what you said?

A. That is probably a soft expression of what I said in the article, I think I say that there is no value to culturing the peritoneal cavity in a patient with acute peritonitis.

Q. In the study you did, let me indicate that unless I'm misreading this you did conclude that 24 percent of people who were sampled in the study that you did had a subsequent change in antibiotic therapy from the empiric selection chosen?

A. That's correct.

Q. So some people do culture and do change based upon what is in the culture?

A. That is correct,

Q. Let me ask you if you've had an opportunity to review Dr. Solomkin's chapter 62 in your book?

A. I haven't read it recently, of course I have read it.

Q. Since it was in your book, when I learned you were going to be an expert I copied it, provided it to everyone so they could review it. I would like to look at page 583.

A, Okay.

Q. Suffice it to say Dr. Solomkin pretty exhaustively covers Candida infection in this chapter, doesn't just talk about intra-abdominal,

agreed?

A. That's correct,

Q. While this is not meant to probably be exhaustive, he does include in the section intra-abdominal abscess and peritonitis, I want to talk about what I interpret to me to be an assertion a person who is receiving immunosuppressive therapy should receive systemic antifungal therapy, do you see that he writes that in the second paragraph?

A. I understand where he writes that, that's correct.

Q. I hope that I didn't misread this. I know you are going to tell me to call Dr. Solomkin, I don't know if he'll return my calls.

Once again this is obviously your textbook, he says, Candida organisms are frequently cultured, doesn't say anything about out of the blood or any place else, from intra-abdominal infections but should be considered a serious threat only in high risk patients. He goes on to define a high risk patient as a person with an antecedent episode of sepsis,

Do you know if Carolyn Yarborough had any antecedent sepsis?

A. She had just the peritonitis identified in this particular case.

Q. Or those who have received immunosuppressive therapy.

He then states in pretty plain English such patients should receive systemic antifungal therapy.

A. That's his opinion.

Q. I gather you disagree with that opinion?

A. I think that is an opinion that I would taylor to the individual patient. That if I received the information on the fourth postoperative day in a patient who has substantially improved, I would not do that.

Again, this is not an egregious or outrageous statement. This a statement of his opinion. All I can say is that all of this has to be framed in the interpretation of the specific patient's situation.

Q. Doctor, you are probably aware, I take it you've gone through the chart sufficiently enough to have looked at the total white blood cell counts for this patient?

A. Yes.

Q. The seventh or eighth day postoperatively she

had a surge in her white blood count; does that comport with your recollection?

A. She had an increase in her white count at that time. I'm trying to filter through the record to identify specifically what you are referring to.

Q. I can probably find it for you. I'm going to represent to you the count was 26,2 I think.

MR. GOLDWASSER: Doctor, if you look at the lab reports, at the bottom the lab sheets are numbered. Page 29 of the lab sheets you'll find where they start on January 12th.

THE WITNESS: All right.

MR. GOLDWASSER: If you have that.

THE WITNESS: Yes, I see.

MR. GOLDWASSER: She is going to show you the 16th where it's up you see from the 12th, so forth.

MISS KOLIS: I believe it's the 16th.

MR. GOLDWASSER: Yes, it's the 16th on page 30, up to 26.

Q. You see it's up to 26. Let me ask you this question: Here is a woman whose been in the

hospital on these antibiotics for seven days, she has got I'm calling it a persistent fever, it is frequently above 98.6, correct?

A. That's correct.

Q. We know that her culture grew out Candida. As a physician would you not have had a concern that she had an increase in her white blood count?

A. I would be concerned.

Q. What would you possibly think was going on that would cause it to surge that way?

A. There could be any of a number of things that could cause a patient on the seventh postoperative day to have a white count go up. It simply requires a systematic assessment trying to define what is the source of the patient's infection.

Q. Did you see a systematic assessment?

A. They clearly noted in the record that they are examining her and following her and so forth, that cultures, additional cultures were taken to try to identify potential pathogens and so forth.

Q. Didn't they take those cultures on the 20th in response to --

A. There is a culture identified if you look at the progress notes on the 16th of January, that is when the cultures were sent.

Q. You know you are right, I'm wrong.
A. All I can say is that I think that reasonable vigilance was being exercised. I'm not sure what one is supposed to do in addition.

Clearly if the patient had an abscess as we know that she subsequently had, that adding antifungal therapy on the 16th to 17th was not going to impact the course of the abscess, it would have to be operated on and drained. So I don't believe, in my review of the records, that event of the 16th constitutes any breach in the standard of care.

Q. I'm sitting here thinking for a minute. I'm looking for something.

What corticosteroid was Nrs. Yarborough on while she was at Saint Luke's?

A. I believe it's Prednisone.

Q. Are you aware she was on anything other than Prednisone?

MR. GOLDWASSER: Was she, Donna?

A. In terms of --

MR. GOLDWASSER: Tell us if she was.

Q. Hydrocortisone?

A. That is part and parcel of the same -- again that is a five fold difference in strength, in glucocorticoid effect. If you multiply Hydrocortisone by five, you come up with Prednisone. You are talking a variation of the same product if you will.

Q. Based on your experience you don't find those two have any different affect on white blood counts, asking if you know?

A. I do not consider them personally to have any different affects upon white blood counts. They have different potencies if you will.

Q. Okay.

A. In terms of the glucocorticoid affect, I would say Prednisone is five times more potent than Hydrocortisone.

Q. I know I have a couple more questions, not many.

Are you going to be asked to render any opinion at trial as to Mrs. Yarborough's life expectancy had this event not occurred?

MR. GOLDWASSER: Wait a minute. In fairness, Doctor, I haven't discussed with you what I'm going to ask you at trial, so you're not a mind reader. Is the question hypothetically if he

is asked that if he has an opinion?

Q. Obviously my purpose today is to find out what you are going to say at trial. Let me put it this way: Hypothetically if Mr. Goldwasser chooses to elicit that testimony from you, do you have an opinion as to what the probable life expectancy of this patient would have been barring this catastrophic abscess incident?

A. I could not make a rational assessment of what the life expectancy would be of a cervical myelopathy patient so at this point I would have no intention of testifying to her life expectancy.

Q. I want to be real clear about this: Going back to where we began, the final sentence of your report, you said Nrs. Yarborough died of severe immunosuppression.

How will you be explaining that to the jury? I can take a shot at it, you could tell me better, because of her immunosuppression it wasn't possible to defend the process going on in her abdomen?

A. No, I would explain it this way: That if one would have used an antibiotic therapy to cover Enterococcus, and if one had used antifungal therapy to cover Candida in this immunosuppressed

patient, she would have died but it would have been with an organism that was resistant to the drug therapy she was being given. That in an immunosuppressed patient, they do not have the capacity to deal with even the most residual organisms, so the fundamental premise of your experts is certainly flawed.

That is to say that if we gave all antibiotics of all kinds to all patients, there would be no infection, that is simply not true.

Q. I don't know they are saying that. Let me see if I understand what you are saying. I think I've added something so I'm glad I reasked the question.

I asked you obviously a long time ago if there was some contraindication to adding antifungal therapy, you told me that was a strong word, it wasn't a deviation from the standard of care not to. I forgot to follow through.

She didn't get additional therapy so she didn't die from the addition of medications, correct?

A. Yes. I'm not saying the medication would would be responsible for the patient's death.

Q. Let's ferret this out. Are you saying she

died of her severe immunosuppression?

A. Let me explain it for you so you understand it.

Q. Okay.

A. The concept of trying to cover every conceivable microorganism is simply not going to work in the treatment of an immunosuppressed patient. It simply comes down to the fact mother nature abhors a biological vacuum. As we add more drugs, we simply precipitate out more resistant organisms. What happens is as you add more drugs, the residual organisms that remain behind are in essence resistant to the drug therapy that you've used.

So that the same clinical circumstances that set the stage for this patient having Candida overgrowth, then Candida sepsis would simply be operational. If you suppress the Candida, there would be something else that would be the overgrowth organism. You simply change the microbe that causes the patient's demise when the patient host's responsiveness cannot address a remaining colonization that exists after a course of drug therapy.

So immunosuppression is really the

disease in this patient, not so much the specific organism that led to her demise,

Q. Should Dr. Sonpal have sat down with the family and told them she was destine to die from immunosuppression?

A. No, because he actually discontinued the antibiotics on the 19th, proceeded with parenteral nutritional strategy which would be an effort to try to resort to a normal nutrition, normal colonization.

It would be my observation, as it was his at the time of her discharge, it fully appeared she had successfully recovered from the catastrophic illness. It would not have been appropriate for him to have counseled the family.

He actually eliminated the antimicrobial pressure, tried to refeed and re-establish normal colonization in the patient, In that sense he was fully compliant with the standard of care in managing this patient.

Q. Have you asked to see the nursing home records?

A, I have not.

Q. You are not curious what her course was in the nursing home?

A. I am curious. I guess I'm curious as to what was her course in the nursing home, why the nursing home may have not perhaps been a defendant in this case, but I was not asked by Mr. Goldwasser to review the nursing home records, so accordingly I've not requested them.

MR. GOLDWASSER: Doctor, as an aside, if it's relevant for your opinion she did well in the nursing home up until the day before she crashed, it was a sudden, relatively sudden acute event.

THE WITNESS: Thank you. I don't think you and I ever discussed the matter.

MR. GOLDWASSER: We have not.

A. I would say in fairness to answering the question, I was curious as to what her course would have been, whether there was any earlier evidence that she was deteriorating, rather than the moments immediately before her demise.

Q. If you had been the surgeon making the decision to discharge this patient to a nursing home, what instruction would you have given that nursing home regarding this immunosuppression?

A. I would have pointed out that she was a patient who was postop from a major abdominal

operation, that she was on immunosuppressive treatment, that infection would be emerging at a point remote from the original operation was a realistic concern. That delayed infection of the abdomen might be an issue.

Probably more importantly things like pneumonia and so forth would have tended to have been more of my focus than a patient who has had a negative CT scan and resumed parenteral feeding having a very late occurring abscess.

I guess more than anything else I would encourage them to give me a prompt call if there was any deterioration in her course so that an appropriate assessment could be made.

MISS KOLIS: Doctor, I don't have any further questions for you,

MR. GOLDWASSER: Dr. Frey, we thank you very much,

(Deposition concluded; signature not waived.)

ERRATA SHEET

NOTATION	PAGE/LINE

I have read the foregoing transcript and the same is true and accurate.

_____

DONALD E. FREY, M.D.

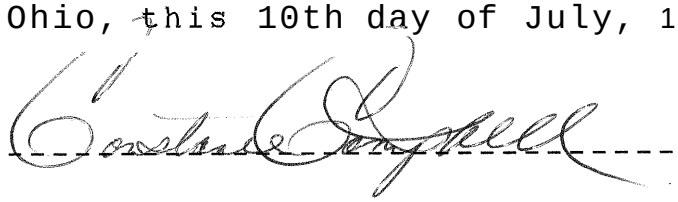
The State of Ohio, :

County of Cuyahoga. : CERTIFICATE:

I, Constance Campbell, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, DONALD E. FREY, M.D. was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 10th day of July, 1998.



Constance Campbell, Stenographic Reporter,
Notary Public/State of Ohio.
Commission expiration: January 14, 2003.

Look-See Concordance Report

- - -

UNIQUE WORDS: **1,330**
TOTAL OCCURRENCES: **3,660**
NOISE WORDS: **385**
TOTAL WORDS IN FILE: **11,492**

- - -

SINGLE FILE CONCORDANCE

- - -

CASE SENSITIVE

- - -

PHRASE WORD LIST(S):

- - -

NOISE WORD LIST(S): **NOISE.NOI**

- - -

COVER PAGES = **4**

- - -

INCLUDES ONLY TEXT OF:
QUESTIONS
ANSWERS
COLLOQUY
PARENTHETICALS
EXHIBITS

- - -

DATES **ON**

- - -

INCLUDES PURE NUMBERS

- - -

POSSESSIVE FORMS **ON**

- - -

MAXIMUM TRACKED OCCURRENCE THRESHOLD: ***50***

- - -

NUMBER **OF** WORDS SURPASSING OCCURRENCE THRESHOLD: **2**

- - -

LIST OF THRESHOLD WORDS:

- - -

Candida [51]
patient [55]

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* * 1 * *

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