IN THE COURT OF COMMON PLEAS

OF CUYAHOGA COUNTY, OHIO

DOC. 156

FRANK PETRILLI,

Plaintiff,

vs. Case No.

THE CLEVELAND

CLINIC FOUNDATION, 160910

Defendant.

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Deposition of KEVIN T. GERACI, M.D., a Witness herein, called by the Plaintiff for examination under the statute, taken before me, Karen M. Patterson, 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 Kevin T. Geraci, M.D., 1611 South Green Road, South Euclid, Ohio, on Thursday, April 19, 1990, at 5:20 o'clock p.m.

pg. 49 & pg. 66 are missing from THIS TRANSCRIPT

APPEARANCES:

On behalf of the PlaintifE:

Greene & Hennenberg Co., L.P.A., by

WILLIAM GREENE, ESQ.

JEAN M. MCQUILLAN, ESQ.

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On behalf of the Defendant:

Reminger & Reminger, by

GARY **M.** GOLDWASSER, ESQ.

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KEVIN T. GERACI, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF KEVIN T. GERACI, M.D.

BY--MR. GREENE:

Q. Doctor, so we can move this along, by way of background, I think you went to Holy Cross undergraduate?

A. That's right.

Q. And you went to Ohio State University Medical School?

A. That's correct.

Q. You did your residency at University Hospitals; is that correct?

A. Yes.

Q. And you did a fellowship in gastroenterology at University Hospital?

A. That's correct.

Q. And you were for awhile the head of gastroenterology for St. Luke's Hospital?

A. That is correct,

Q. Are you board certified in gastroenterology?

A. Yes.

Q. At some point you left St. Luke's Hospital to come over to University and Suburban Hospitals; is that correct?

A. About eight years ago.

Q. And you do now a general internal medicine practice?

A. Gastroenterology as well as having a practice on the side as well.

Q. Now, I received a letter from you dated December the 19th, 2989, and I am going to ask you, prior to writing this correspondence, what materials did you go over?

A. None.

Q. Did you go over the medical records of the patient?

A. Yes.

Q. Did you reference --

A. I thought you meant references.

Q. Did you reference any literature?

A. No, I didn't.

Q. Have you since then referenced any literature in preparation for this deposition?

A. No. I pause there, because I had a

grand rounds, but it was a grand rounds on high -- colonoscopy in high risk groups and screening high risk patients, so it covered some of the screening areas.

Q. Now, we are here in the library of your medical practice; is that correct?

A. Yes.

Q. And I see among us in the library the Journal of Lancet.?

A. Yes.

Q. And the Journal of Cancer?

A. Yes.

Q. Those are two journals which your practice subscribes to?

A. The building does, yes.

MR. GOLDWASSER: Let's be fair. We are in a very large suburban medical building, which also is an ambulatory surgical center.

A. I'm not; sure we subscribe to Cancer. Cancer, yes. I was wondering whether we had CA, which is the Journal of The American Cancer Society, which is a --

Q. Do you yourself read the Journal of Cancer?

A. I will. I will when I'm looking

for something specific and they have that article in it,

Q. And Gastroenterology, is that a periodical that you would read?

A. Yes.

Q. And Lancet, is that a periodical that you would read if there is articles in it about gastroenterology?

A. Yes. If there is an article, again, pertaining to a subject that I might want to read about.

Q. As far as general reference books in gastroenterology, I see one of them on the shelves here that's Sleisenger and Fordtran?

A. Yes.

Q. Is that a book that you would utilize from time to time in your practice, doctor., for reference material?

A. Not that one.

Q. which one would you use?

A. Fourth edition.

Q. When that was current, you would have used the third ed; is that correct?

A. Yes.

Q. Do you know Dr. Owens, Dr. Frank

Owens?

A. I think I know who he is. I certainly have met him at a meeting. I haven't talked to him in maybe five, maybe eight years.

But you do know him?

A. I do know him. I know him enough to say -- after, say a city-wide meeting, passing by, say hi, and he would say hi back.

Q. Do you belong to any associations with him, medical associations, with him?

A. I don't think he belongs to the Academy of Medicine. I don't know what societies Ire belongs to, if he belongs to the American Gastroenterologic Association, but it's not like social --

Q. Right.

A. -- or even anything around town that I *see* him at.

Q. I just wanted to know if you belong to any associations with him.

A. I don't know.

Q. Have you ever testified as an expert.. in a medical malpractice case?

A. Yes.

Q. About how many occasions?
A. Too many. Probably one every six months.
Q. And for what period of time would that have been?
A. Maybe ten years.
Q. Has most of your testimony been on behalf of the physician?
A. Yes.
Q. Have you ever testified against a physician in the Northern Ohio area in a malpractice case?
A. I don't know. I might have, but I don't know -- I can't; recall a case.
Q. Do you have a recollection?
A. I can't recall doing that.
Q. Have you ever had an opportunity to read the deposition of Dr. Owens?
A, No, I don't think I have,
MR. GOLDWASSER: Do you want to know what I sent him, Bill, or don't you care?
MR. GREENE: Sure.
MR. GOLDWASSER: I was just looking at my letter. I sent. him the records of Cleveland Clinic that are relevant to this. I

didn't send him everything. I sent him the Cleveland Clinic admission of March of 87.

I also sent the doctor a memorandum prepared by my paralegal, and I sent him a report, of the Plaintiff's expert. The memorandum is just a summary of the medical.. records.

Q. Doctor, you have a copy of your report in front of you, do you not?

A. Yes.

Q. Now, you wrote this report on December 19th, 1989?

A. Yes.

Q. Had Dr. Owens saw Mrs. Petrilli on December the 18th, 1989, would your criticism or opinion of this case be any different?

A. Yes.

Q. In what respect?

A. I think in the past four years, colonoscopy has become used more frequently, and I think double contrast barium enema studies have come on as a more accurate test. I think the numbers for them picking up right-sided lesions would be such that one of the two studies -- an argument could be made

very much more strongly now for doing one of the two studies in that particular case. I'm not sure back in 1985 things were that way.

Q. Is it your opinion then, doctor,

which appeared in the Journal of the American Medical Association in 1989?

MR. GOLDWASSER: Bill, let's read it into the record.

MR. GREENE: This is Detection and Surveillance of Colorectal Cancer,

A. I've read this, yes, I haven't read it lately, but I'm familiar with it, yes.

Q. Let me see this just for a second,

MR. GREENE: I can give you a copy of it.

MR. GOLDWRSSER: Just for the record, it appears in JAMR, January 27, 1989, authored by Fleischer, et al.

MR. GREENE: Thank you.

Q. Are you a member of the American Gastroenterological Association?

A. Yes.

Q. Arid referencing this article which you read, this article was, I believe, approved by the governing body of the American Society of Gastrointestinal Endoscopy and the American Gastroenterological Association, do you recall that?

A. I don't recall it, but --

Q. And one of the signers off on this article is Dr. Victor Fazio, chairman of the division of colorectal surgery of the Cleveland Clinic Foundation. Do you know Dr. Fazio?

A. Probably as well as I know Francis Owens.

Q. Do you know what type of stool guiac test Dr. Owens administered on Mrs. Petrilli?

A. I would have to review the records, but I'm sure it was a hernocult test.

Q. Doctor, do you treat patients, middle-aged women who present with rectal bleeding, with a history of rectal bleeding?

A. Yes, I do.

Q. And if, after your workup -- I'm referencing 1985 now --

A. 1985. This is important with the hemocult test:.

Q. I understand that. Referencing 1985, you saw patients in 1985, middle-aged women who presented with a history of rectal bleeding; is that correct?

A. Yes.

Q. After your taking the history and

doing the physical exam, in your differential diagnosis, you listed colon cancer as a possibility, polyps, adenomatsus polyps as a possibility, along with all of the number of other things that you might list, would it be your obligation to rule out colon cancer or adenomatous polyps if they appear in your differential?

A. Obviously, the way you phrased the question, it would be yes.

Q. I'm asking you to assume that Dr. Owens did a differential, and in his differential he had colon cancer in Mrs. Petrilli and adenomatous polyps.

A. Yes.

MR. GOLDWASSER: Is that the facts in this case?

MR. GREENE: That's Dr. Owens' testimony.

MR. GOLDWASSER: That is the testimony?

A. It's not in his notes, but --

MR. GREENE: That's his testimony. I could reference you page number, if you want, right now.

MR. GOLDWASSER: Would you? Do you have it there?

MR. GIIEENE: Yes, I do.

MR. GOLDWASSER: He hasn't seen the testimony.

A. I haven't seen the testimony, but if it's in his notes, fine.

Q. It's not in his notes. It's in his deposition testimony.

A. Okay.

Q. Page 31, line 11, Dr. Owens' testimony, I asked him --

MR. GOLDWASSER: I believe you, You just; tell me where it's at, that's all,

MR. GREENE: Page 31, line 11.

MR. GOLDWASSER: And where else? He said that at the time he saw this lady he had a differential diagnosis of cancer?

MR. GREENE: Yes, colon cancer.

MR. GOLDWASSER: Okay. What else did he say?

MR. GREENE: He said it was, in his differential, adenomatous polyps.

Q. Were you familiar with the fact that Mrs. Petrilli complained, arrd I believe

it's in your correspondence,. of having blood in her bowel movement, referencing your third sentence, bright red blood in her bowel movement; is that correct?

A. It was seen in the form of stool, yes.

Q. And the bright red blood that was seen in her bowel movement was described by Mrs. Petrilli in her medical records of being,. quote, unquote, braided in her stool. Are you familiar with that?

A. Yes.

Q. Does braided in her stool mean anything to you, doctor?

A. I think Mrs. Petrilli, in looking at that; note, I would think Mrs. Petrilli looked at her stool and saw blood mixed on the top of it, or braided in, yes.

Q. Well, does the word "braid" have any significance to you?

A. I'm not sure it does, no. I don't think it does.

Q. All right. The word "braid" means to weave or intertwine, does it not, doctor?

A. Fine.

MR. GOLDWASSER: We don't know if that's what she meant. That's quote, unquote, whatever she meant by braided.

MR. GREENE: Don't testify. Let him testify.

A. Unless she is extremely compulsive, I would think she would be like any other patient and look at her stool., the surface, and see there is blood in there,

Now, braided may be what's on there, but I doubt if she picked it up in her hands and went through it and sifted to see if there was blood in the center as opposed to the surface.

Q. She saw blood in her stool?

A. On the surface.

Q. Well, according to the note, Dr. Owens' note, it says blood in her stool, does it not, his note? Do you want to reference his note?

A. Blood in her stool and on the toilet paper.

Q. And on the toilet paper. That's correct?

A. That's correct.

Q. Now, do you know whether or not Dr. Owens was able to demonstrate bleeding from the hemorrhoid which he said he saw, the internal hemorrhoid?

A. No, he wasn't. It was not bleeding and there was no -- and it was hernocult negative, the stools.

Q. Well, getting back to your differential, in 1985 if colon cancer appears in your differential of a woman who comes in with complaints of bright red blood in her bowel movement and on the toilet paper, you would trave an obligation, would you not, to rule out the cancer or the polyp; is that correct?

A. As you phrased the question, *yes*, I would.

Q. Okay.

A. If you would -- at. some point I would like to make the point.

Q. I'll let you explain a Little bit later on, but Mr. Galdwasser is going to have you at trial and you will be able to do a lot of talking there.

A. Okay.

Q. And, doctor, you would agree that there is substantial evidence to suggest that most of:, most, if not all, colorectal cancers arise from preexisting adenomatous neoplastic polyps; is that correct?

A. That's correct.

Q. And these polyps -- you are familiar with the guidelines for screening of the American Cancer Society as to colorectal cancer? Are you generally familiar with those?

A. I am.

Q. Okay. And in a middle-aged woman, the guidelines provide for, among other things, a sigmoidoscopy every three to five years?

A. Yes.

Q. And that's based upon the fact that it's known that colorectal polyps grow slowly; is that correct?

A. It's based on the fact that approximately 70 percent of colorectal cancers occur within the reach of a sigmoidoscope.

Q. But that's the three to five-year interval, doctor. It's based upon the fact that once there is a clean colon seen, or at

least sigmoid colon seen, that it would take at least three to five years for a polyp to grow?

A. That's correct.

Q. And some of those polyps go on and become cancerous, don't they?

A. Yes.

Q. And it takes a number of years for those polyps to go through the polyp/cancer transformation, doesn't it?

A. Yes, it does.

Q. And it's thought that the least amount of time it would take for a polyp to become a cancer is two years; isn't that correct, doctor'?

A. Yes.

Q. And it may be --

A. Now, wait a minute now. I don't -- I'm not sure that that's correct. I mean, I understand what you are saying, but I think from my point of view, 1 don't think I could agree a hundred percent there.

Number one, there are certain cancers that are very malignant in their activity and very aggressive and they don't take a period of time to go from adenomatous to

villus to cancer. I think there are very small polyps that are very aggressive and they don't take two years to go.

Q. Well, doctor, isn't the estimate actually that it takes them seven to ten years for an adenoma to progress to a malignant cancer?

A. Those are certain studies based on probably -- well, it's more the work of a pathologist, but I could quote you other studies that those numbers are off, that there are certain conditions, particularly right-sided colon cancers, that don't behave that way.

Q. But first you have an adenomatous polyp growing from normal gastric mucosa?

A. Not necessarily.

Q. But that is the generally accepted theory, that almost all colon cancers --

A. The theory begins with screening.

Q. And the general theory put forth by the ACS and your association, doctor, for the three to five years for a sigmoidoscopy is based on evidence and estimates of seven to ten years for an adenoma to progress to a malignant

cancer; isn't that correct?

A. Yes, that's correct.

Q. In a study by Gilbertson and Nelms, no patient was found to have a rectal cancer within seven years of a negative sigmoidoscopy; isn't that correct?

A. That's correct.

Q. In mathematical modeling, it's suggested there is an interval of three to five years between examinations because that would appear to be safe, would it not?

A. That's correct.

Q. Now, early colorectal cancer produces no symptoms in general; isn't that correct, doctor?

A. I think that's a broad generalization. I think it depends where the cancer is. You can have a rectal, cancer that will bleed bright red blood.

Q. But, doctor, early --

A. Early.

Q. -- early cancer may produce no symptoms at all?

A. Early cancer may produce no symptoms.

Q. And a lot of what you do -- do you do colonoscopies, doctor?

A. Yes.

Q. Did you do colonoscopies in 1985?

A. Yes.

Q. As a matter of fact, colonoscopies have been around since 1971, haven't they?

A. I'm trying to think. 6970.

Q. When did you start doing them?

A. 1970.

Q. And double contrast barium enemas, how long have they been around?

A. I'm not sure, because I never really was a big fan of double contrast barium enemas until last. year or the year before.

Q. Rut they have been around for some time, haven't they?

A. Maybe -- I don't know if -- how germane they are to this discussion. I'm not sure what they were doing with double contrast barium enemas in 1985,

Q. Barium enemas have been around for a long time, haven't they, doctor?

A. That's a difference.

Q. They have then?

A. But I'm sure you know there is a big difference between the barium enema and the --

Q. I understand that, but barium enemas have been around for a long time, haven't they, doctor?

A. Yes.

Q. Now, in 1989, why would you have looked on the right side of Mrs. Petrilli's colon if you were her treating doctor?

A. I'm not sure you're going to like this answer, but I think we are more --

MR. GOLDWASSER: I'm going to object to the question.

A. I think we are more mechanical, or more technician oriented in 1989. 1985 and earlier, we were still relying quite a bit on clinical judgment and the art of medicine, and I think as the years have gone by, for a number of reasons, I think one of which is, quite frankly, financially you can justify it, where before I think people would say what the hell are you doing putting a colonoscope in everybody who walks in your office.

So I think in 1989 we are more apt

to be blind and not rely as heavily on history and physical examination.

Q. Did you train under Dr. Dworken?

A. Yes, I did.

Q. Do you accept him as being someone who has expertise in the area of the diagnosis of colorectal cancer?

A. I think as much as I do,

Q. But you did train under him?

A. Yes.

Q. Do you accept that you can yet. bright red blood on the stool from a right-sided Pesion?

A. I don't accept that.

Q. You don't accept that?

A. I don't accept that.

Q. Okay.

A. I think if you read my letter, I have never seen that,

Q. You haven't seen that?

A. I've never seen it.

Q. Doctor, your letter says, to be fair, you have never seen in 20 years bright red bleeding -- I have never in my 20 years of practice as a gastroenterologist seen a right

colon to present with a history of bright red blood on the tissue and hemocult negative school. Isn't that what you said?

A. Yes, and I can expand that to say bright red blood on the stool.

Q. Are you saying that's not well documented in the literature, doctor, that bright, red bleeding can present --

A. I'm saying 20 years of experience as a gastroenterologist holds up darn well against your quoti-rig little --

Q. The lit --

A. -- little remarks within the Literature.

Q. Doctor, the literature --

MR. GREENE: Am I interrupting?

MR. GOLDWASSER: You are interrupting the witness.

MR. GREENE: I'm sorry.

A. I would like to stand on that. I think 20 years of practice as a gastroenterologist means a hell of a lot more than somebody researching the literature.

As somebody in academic medicine, I'm quite aware that any point of view I want

to take i.n an academic argument I can go to the literature and find something to back me up, so you can quote me articles all day long, and I know you will, hut that doesn't change my clinical impression of how I see things at the moment .

Q. Are you done?

A. Yes.

Q. Doctor, have you seen right-sided colon cancers presenting with bright red blood in the stool and a positive guiac test?

MR. GOLDWASSER: What was that last one?

MR. GREENE: Positive guiac test.

A. No.

Q. Doctor, the literature is made up not only of a singular gastroenterologist's experiences, but also in part the collective experiences of many doctors and many health centers throughout the country; isn't that correct?

A. I think the literature, if it's quoted properly, would be just what you said, yes.

Q. And --

A. And by quoted properly, I mean not to grind in an ax of a point of view.

Q. Doctor, would you agree that rectal bleeding, visible or occult, is commonly associated with colorectal cancer?

A. That is correct.

Q. Would you agree that the passage of bright, red blood per the rectum is most often seen with lesions of the rectosigmoid?

A. Yes.

Q. Would you agree that it can also be seen with cancer anywhere in the colon?

A. Not as a symptomatic presentation.

Q. Okay. Just so I can be clear, I'm reading from a special communication that I referenced earlier which says rectal bleeding, visible or occult, is commonly associated with colorectal cancer. The passage of bright red blood per the rectum is most often seen with lesions of the rectosigmoid, but can be seen with cancer anywhere in the colon.

Do you disagree with that?

A. No. No. I think incidental bright red blood on the surface of a stool can be seen with cancer of the brain; it can be seen with

cancer of the lung, but it doesn't mean that that particular cancer is causing the symptom.

Q. Okay. So what you are saying, doctor, is that even though there is bright red blood seen on the stool with cancers anywhere in the colon, it wouldn't be seen from cancer on the right side of the colon?

A. It wouldn't be the presenting symptom of right-sided colon cancer.

Q. It would not?

A. It would not.

Q. Do you have any literature that supports that;, doctor?

A" I don't at the moment. I can say in my 20 years of experience I've never seen it.

Q. I'm just asking, doctor, do you have any literature that supports that?

A. That supports that point, no.

Q. How many right-sided colon cancers have you treated?

A. Triple figures. I don't know. I don't --

Q. Would it be over a hundred?

A. Over a hundred, yes.

Q. Over 200?

A. Possibly. I don't put notches on my colonoscope, but I'm sure there are over a hundred, yes.

Q. But would it be over 200?

A. Possibly.

Q. Would it be over 300?

A. I have no idea. I would probably -- it might be. I don't know.

Q. Isn't it also true, doctor, that the literature states, in essence, that hemorrhoidal bleeding in a middle-aged person, hemorrhoidal rectal bleeding, should never be attributed to hemorrhoids without an examination of the entire colon?

A. Without a sigmoidoscopy.

Q. Isn't it also true that, as stated, it should be a diagnosis of exclusion which would involve looking at the entire colon?

A. With a colonoscopy for bright red bleeding on the tissue and the surface of the stool., I think that can be argued.

Q. in stool, doctor.

A. On the surface of stool.

Q. Do you know where the blood was,

doctor?

A. Do you know where it was? I think it was on the surface of the stool.

Q. Is there a difference, in your mind, between blood on the surface of the stool and blood in the stool?

A. Blood in the center of the stool, yes, would mean, I think, to me that it might he 35, 40, up a little higher, yes, as opposed to -- do you want to hear where I think the symptom of blood in the stool., how it goes, as Ear as where you are looking for a lesion?

Q. Yes.

A. If you do, I would say that bright x-ed blood seen in the commode, whether it be free or on the surface of the stool, would come from, in all probability, from the left side of the colon within the region of the sigmoidoscope.

Q. What size sigmoidoscope are you talking about, doctor?

A. Flexible sig.

Q. 35 centimeters?

A. A flexible sig is a 50-centimeter scope.

Q. Did Dr. Owens look up to 50 centimeters?

A. He went to 35.

Q. So he missed everywhere between 35 and 50 that you think the blood might have come from?

A. Well, again, I'm saying that we are -- you know, you are going to -- I think they have 15 centimeters I can't: account for. I think if we were arguing today a case where a colon cancer was missed on the left side of the colon, I wouldn't be testifying, because I would say it was missed,

Q. Doctor, would you agree that, in all probability, that cancer was on the right side of the colon?

A. Excuse me, you didn't let me finish my explanation of where the blood in the stool comes from.

Right-sided lesions, to me, would ordinarily present as hemocult positive presentations, occult bleeding.

If there is an erosion into a vessel from this lesion, you'll see bright red blood, but it won't be in the form of stool;

you'll have Like we had talked about earlier, a massive hemorrhage or bloody diarrhea, but it will not --

Q. You can't get bloody stools, red bloody stools, From right-sided lesions; is that correct? Is that what.. you are saying?

A. You could have entirely uniform red stools, I have seen that, of a red -- semi-formed red, possibly formed, but not braided. Braided to me means it's more going left for the simple reason that by the time the stool moves from the right side to the left side, things happen to it. The stool can -- the blood can undergo color changes that will, make it blend in with the stool.

Q. In actuality, doctor, isn't the literature quite clear that you can have bright red bleeding on the stool from lesions anywhere in the colon? Can you answer that yes or no? The literature, not your experience, but, just the literature.

A. Let me answer your question, but make sure I understand it. You are saying that the literature says -- you are asking me, first of all --

Q. I'm asking you, from your understanding, doesn't the literature support the proposition you could have bright red blood on the stool from lesions anywhere in the colon?

A. No.

Q. Right side or left side?

A. No.

Q. Thank you. But you know of no literature that supports what you just stated, that you cannot have bright red blood in the colon?

A. On the surface of the stool from right-sided colon cancers.

Q. In her bowel movement, bright red blood in the bowel. movement from right-sided lesions.

A. As we have been talking about, on the surface of the stool or, as you like to call it, braided, as she looks in the toilet at ehe stool --

Q. Whatever you want to say, *yes.*

A. A streak of blood.

Q. Where is the literature that says that that; cannot come from a right-sided

lesion?

A. I'm sure I could show it to you. I mean, it's literature, it's there. I'm not in any --

Q. Will you briny that t.o the trial with you, doctor?

A. Oh, I would be happy to.

Q. Thank you. AS far- as your training, you were trained, were you not, that hemorrhoidal bleeding is a diagnosis of exclusion?

A. Hemorrhoidal bleeding is a diagnosis you make when you look with an anoscope.

Q. Bright red blood from a hemorrhoid that you cannot demonstrate bleeding on is a diagnosis of exclusion, is it not?

A. I don't understand what you just said.

Q. Okay. We will *go* on.

A. You could rephrase it.

Q. I will. I will.

A. Okay.

Q. Doctor, when you assume that. Mrs. Petrilli was guiac negative on the examination

of July the 16th, are you assuming that she had a guiac test?

A. Hemocult test.

Q. A hernocult test,?

A. Yes,

Q. All right. When you give, in 1985, a patient a hemocult test, do you follow the general guidelines for the hemocult test of the American Cancer Society and your Gastroenterological Association?

A. 1985?

Q. Yes, 85.

A. I tried to.

Q. As a matter of fact, you are concerned with false negatives and false positives in that. test, are you not?

A. Yes, I am.

Q. And --

A. More so in 89 than in 85.

Q. But you were concerned about that?

A. Yes. Actually, I'm not sure I was so sensitive to the false negative rate in 1985. In fact, I can assure you I wasn't, In 1985, a hemocult test meant a lot more, if it were negative, than it does now.

Q. Doctor, isn't it a fact that if you just take one specimen of stool and do a hernocult test, that one specimen can yield a 50 percent false negative rate?

A. That's correct, in 1989.

Q. It was still a 50 percent false negative in 1985, wasn't it, doctor?

A. That information was not known then. It wasn't disseminated then.

Q. It wasn't known then?

A. It was not disseminated then. I can remember the first time I read that as a gastroenterologist.

Q. Doctor --

A. The first time --

MR. GOLDWASSER: Let him finish.

A. I read that in the American College of Physicians Medical, what they call, Medical Knowledge Self-Assessment Syllabus, and that I read in 1987, no earlier.

Q. So if that appears in the --

A, That was the first time, and I feel like I'm a pretty well-educated practicing gastroenterologist. If I learned that in 1987, then I'm not going to hold anybody to task for

not knowing it in 1985.

Q. The recommendation in 1985 -- the recommendation in 1980, doctor, was to do three tests on --

A. The three versus one is not the issue.

Q. Can I finish, please?

A. Yes.

Q. All right. -- was to do the test on three consecutive days after proper preparation from two separate pieces of stool on each of those days; isn't that correct?

A. That's correct.

Q. Isn't that the recommendation in 1980?

A. That's correct.

Q. And that's how you proceeded when you tested patients in 1985, did you not?

A. No. I did a rectal exam and checked their stool for blood. If it was negative, I assumed it to be negative, as Francis Owens did.

Q. If it was negative, you were looking in the face of a 50 percent false negative rate, were you not?

not knowing it in 1985.

Q. The recommendation in 1985 -- the recommendation in 1980, doctor, was to do three tests on --

A. The three versus one is not the issue.

Q. Can I finish, please?

A. Yes.

Q. All right. -- was to do the test on three consecutive days after proper preparation from two separate pieces of stool on each of those days; isn't that correct?

A. That's correct.

Q. Isn't that the recommendation in 1980?

A. That's correct.

Q. And that's how you proceeded when you tested patients in 1985, did you not?

A. No. I did a rectal exam and checked their stool for blood. If it was negative, I assumed it to be negative, as Francis Owens did.

Q. If it was negative, you were looking in the face of a 50 percent false negative rate, were you not?

A. And I still am.

Q. But you don't rely on that test to proclaim that your patient's stool is either positive or negative; isn't that correct, doctor?

A. Well, I did that.

Q. You did?

A. Yes.

Q. You are familiar, though, with the fact that that test was recommended on three separate days as long ago as 19803

A. Yes, but, see, we are talking about somebody coming in the office with a complaint of bright red blood.

In those days, in 1985, we would assume that if it were positive then, basically it would probably be positive immediately during the exam. The concept of how falsely negative the hernocult test could be really has evolved more so -- and been emphasized much more since then.

Q. Doctor, I'm reading from an article in 1980 that appeared in Cancer, Screening for Colorectal Cancer.

A. Screening for Colorectal Cancer,

and let's keep it in. context.

Q. Can T finish my question?

A. No. Let me finish what I'm saying.

Q. In 1980 in Cancer, the Journal of Cancer, they are recommending a test, the patient prepare six smears in three days froin different parts of stool. specimens; isn't that correct?

A. Now, let me explain, if we are screening a population for colon cancer.

Q. I'm going to ask you, first, isn't that correct,?

A. I'm not going to answer that question, because you cut me off from before. I'm going to answer as I think it should be answered.

MR. GOLDWASSER: I disagree with you. You and I went through this about ten years ago,

I want you to know, as a lawyer, I don't agree with him. So you heard a lecture on what: Bill Greene thinks the law is, and I disagree.

A. Okay, all right.

Q. Doctor, I'm reading to you from an article in 1980, and I'm only asking you, are you familiar with the article that appeared in Cancer, Early Detection of Colorectal Carcinomas?

A. Who is the author?

Q. Gilbertson.

A. Yes.

Q. Victor Gilbertson you would consider to be an expert in the area of colorectal cancer?

A. Screening, screening large populations for colorectal cancer. I don't know if he never --

Q. In 1980, the conclusion of his article, doctor, he says in the second last sentence, colonoscopy, this is 1980, is

recommended as an integral portion of diagnostic evaluations of persons found to have blood in the stool.

Would you agree with that?

A. Hemocult positive blood in the stool, yes.

Q. We would agree in 1985, around Memorial Day, that Mrs. Petrilli had blood on her stool --

A. She was hernocult negative.

Q. Correct, and you think that she was hemocult negative in 1980 with visible blood in her stool?

A. I have no evidence in any records that she was ever found to be hemocult positive.

Q. In other words, doctor, if you see gross blood on the stool, you consider that to he hemocult negative?

A' If I'm testing, I see gross blood, I'll test it with guiac test arid it will turn blue.

Q. If she had gross blood. an her stool, you would assume she was hernocult positive at that-, time?

A. If my office and I checked her and she was hemocult negative in 1985 --

Q. I'm not asking you that.

A. I think that was one of the issues here.

Q. If a patient has blood on her stool, gross blood, she is considered to be hemocult positive, is she not?

A. No, she isn't. It means you put a sample from a finger or a stool on a card, put a developer on there, and it turns blue. That is by definition hemocult positive.

Q. You would assume --

A. I try not to make assumptions.

Q. Doctor, if she had visible blood on her stool and the portion of her stool that has blood on it is put on a hernocult card, she is hemocult positive, isn't; she?

A. Yes, she is.

Q. It would be fair to say that in May of 1985, from what you know about hemocult tests, that she would have been hemocult positive on those days -- I'm not talking about later on; on those days -- isn't that fair to say?

A. I think there are variables.

Q. Is that fair to say?

A. I think there are variables of what you are saying.

Q. You can't answer that yes or no?

A. I don't know about her stool, if it were positive or not. I think if you found blood on somebody's skin or on tissue and you tested it for being hemocult positive, it would be hemocult positive, but that's not saying it's coming from the GI tract, number one. It's not saying her stool is positive, number two.

All I'm saying is if she had gross visible blood on her stool, that would be considered to be hemocult positive, would it not? Is that a fair statement?

A. Yes. I think that would be a fair statement.

Q. And you would also agree that colonic neoplasms, such as carcinomas and polyps, bleed intermittently, do they not?

A. Yes, they do. They may. I mean, they may, yes.

Q. That's one of the reasons, among

other things, why you do these tests, the stool guiac tests, on successive days to try to reduce the false negative rate by doing successive stool samples on different days because they bleed intermittently? That's one of the reasons; correct?

A. Yes.

Q. So the fact that she was guiac negative on one test on July 16th, 1985 doesn't mean that she would have been guiac negative on July 17th, 1985; is that correct?

A. Yes.

Q. Would you agree, doctor, in 1985, with Dr. Gilbertson that colonoscopy is recommended as an integral portion of diagnostic evaluations of persons found to have blood in the stool?

A. Guiac positive blood in the stool. Guiac positive stool, I would consider that, yes.

Q. Well, would you agree with his statement that persons found to have blood in the stool, that colonoscopy is an integral portion of the diagnostic workup?

A. No. I think you are taking it out

of context.

Q. Now, doctor, had Mrs. Petrilli not had an internal hemorrhoid when she was examined in 1985, would you have expected Dr. Owens to then search for a bleeding point that was responsible for her bloody stools?

A. I think he -- I would have -- if there were no hemorrhoid --

Q. No hemorrhoid.

A. No hemorrhoid, I would have done a sigmoidoscopy, no hemorrhoid bleeding.

Q. If your sigmoidoscopy was negative, you would still have not identified a cause for her colorectal bleeding; is that correct?

A. That's correct.

Q. And you then would have looked further, would you not, doctor?

A. I'm not sure I would have.

Q. Do you know either way?

A. I can probably cite you cases where I didn't.

Q. Would you have --

A. In 1985.

Q. Would you have scheduled her for a stool yuiac test?

A. I would have thought pretty much about that, yes.

Q. Would you have suggested a followup stool guiac test for this woman at any time in the future?

A. Yes.

Q. Six-month interval?

A. Within six months,

Q. Now, you are aware that Dr. Owens recommended no followup on this patient, are you not?

A. I see no followup,

Q. And that would not be consistent with acceptable practice in 1985 not to follow up on this patient with a stool guiac test at a six-month interval?

MR. GOLDWASSER: Now, wait a minute. Your premise is he found no internal hemorrhoids, In his record, he found internal hemorrhoids.

Q. Let's go hack, doctor. What percentage of the female population past 50 have internal hemorrhoids?

A. That have internal hemorrhoids, I would say probably 50 percent.

Q. And there is a difference, in this type of examination, if you are able to demonstrate bleeding from the hemorrhoid as opposed to when you see a hemorrhoid that's not bleeding; isn't that correct?

A. That's correct.

Q. And in this case, Dr. Owens was not able to demonstrate bleeding from that hemorrhoid?

A. That's correct.

Q. So let's say assuming he saw the hemorrhoid and thought that was the reason far --

A. We? are talking hemorrhoids?

Q. Let's talk hemorrhoids for a second.

If he saw hemorrhoids and thought that was the reason for the bleeding but was unable to demonstrate bleeding from that hemorrhoid, would you have expected him to have recommended a followup for her?

A. I would. have told her to come back if she sees some more bleeding,

Q. Doctor, the recommendations for screening in 1985 of asymptomatic patients with

no bleeding at all would be to do yearly stool guiacs; is that correct?

A. That's correct.

Q. Do you have any indication from the records that prior to 1985 anybody had ever worked up Mrs. Petrilli for colorectal cancer by doing any screening tests?

A. No, I don't have any.

Q. Would you agree that it would have been incumbent on Dr. Owens, given his impression that this was hemorrhoidal bleeding, but bleeding that he could not demonstrate, to to have informed her of the need for followup for her condition?

A. Again, I think he would -- he would be required to tell her that if she sees some more rectal bleeding, to get in there soon so he could investigate it.

Q. would you expect him to inform her of the need for followup stool guiacs?

A. I think as a general health issue, it would be of some value. I think as far as having identified a high risk person, I don't think he had.

Q. I'm talking about ordinary risk of

3 screening. That's population screening that I don't think is very good one way or the other.. I don't think it's a good picker upper of cancer, I don't think it's a good rule out or detector of cancer.

So, I mean --

Q. You don't think the stool guiacs are really very reliable?

A. I don't,

Q. So what we have here is a woman who comes in with four days -- with a history of four days of bloody stools --

A. Not bloody stools, Blood on the surface of her stool and on the tissue,

Q. Doctor, she was described as having blood in her stool by Dr. Owens; isn't that correct? In Dr. Owens' note, it; says blood in her stool?

A. Blood that she saw in her stool.

Q. And all you know about what the stool looks like is the history that she gave to Dr. Owens?

A. No. No. We have the description of braided.

Q. Braided blood?

A. Yes.

Q. which means blood intertwined; is that, correct?

A. That's correct.

Q. So that would suggest blood in the stool, would it not, doctor?

A. Again, we have been over this blood on the surface of the stool, and to me the biggest -- go ahead.

Q. And once again, Dr. Owens didn't see the blood on the stool, you didn't see the blood on the stool, and you didn't even talk to the patient; is that correct?

A. That's correct.

Q. And Dr. Owens has no memory of this patient other than what's written in this chart.

MR. GOLDWASSER: So what's your yuestion?

Q. The point is: You don't know whether they were bloody stools or not bloody stools? They were stools with blood on them; correct?

R. Stools with blood on them, exactly.

Q. Blood that the patient recognized --

A. Yes.

Q. -- as being blood?

A. Yes.

Q. Now, the object of doing colonoscopies and double contrast barium enemas and sigmoidoscopies by gastroenterologists is to find lesions in a state where they can be removed and a patient can be cured, hopefully; isn't. that correct;?

A. Yes.

Q. That's why you are doing --

A. Or to pick up a cancer that you have to deal with.

Q. That's potentially curable; correct?

A. You pick up incurable ones, too.

Q. Is it fair to say that, in all probability, which is 50 percent or more, that khat four-by-two centimeter lesion that appeared in her sight colon that we know she had in early 1987 was there either as an earlier cancer or as an adenomatous polyp in 1985?

A. In all probability.

Q. Arid the colonoscopy that you do, doctor, that you were doing in 1985, has an accuracy rate of over 90 percent in picking up polyps and cancers, doesn't it, doctor?

A. Cecal cancer is probably a little lower, 85 to 90.

Q. You would expect that, had Dr. Owens done a colonoscopy, that he would have found the lesion in the cecum?

A. I think that's debatable.

Q. I'm just talking percentages, doctor.

A, Percentages we have to figure, what do you get to the colon, what do you get to the cecum.

Q. If you didn't get to the cecum, he had available to him a double contrast barium enema?

n. I don't think Ire did in 85. I wouldn't have.

Q. Do you know if the Cleveland Clinic was doing double contrast barium enemas in 85?

A. I don't know, and I don't know how good they were, if they were.

Q. They were doing colonoscopies in the 70's at the Cleveland Clinic, were they not, doctor?

A. I would suppose.

Q. You have no information to believe that hers was the type of colon that you wouldn't be able to do a colonoscopy all the way to the cecum, do you, doctor?

A. I think we had lower rates getting to the cecum in 85.

Q. You would have expected, though, he could have done it to the cecum, given the ordinary population?

A. I would give him probably about -- the Cleveland Clinic, I think Mike Sivak probably says they probably get; there about 80 percent of the time.

Q. You would have anticipated, in all probability, had they looked at that time, they would have found something in the cecum, to a probability?

A. If they could have gotten there.

Q. And you would have expected that 80 percent of the time they would knave gotten there; correct;?

A. Yes.

Q. And whether or not they would have found a polyp or a cancer, you don't know?

A. I don't know.

Q. But they would have found a cancer at air appreciably earlier stage, would they not, doctur?

A. You know, I really don't know that. either. I --

Q. You would assume that., would you not, doctor?

A. I would assume that. I would also have to assume this wasn't a very highly virulent cancer, but it could have been a cancer that developed very quickly, and I don't know. You know, I think we have talked over those figures --

Q. But in all probability --

A. -- and the reservations about the figures of right-sided lesions.

Q. But, in all probability, doctor, they would have found it ah; an earlier stage; correct?

A. Yes.

Q. And would you agree, doctor, that

if the cancer has arisen and is picked up early, then your chances of being cured are greater the earlier it's picked up?

A. Yes.

Q. And if the cancer is confined to the bowel wall, you have a 90 percent chance of being cured with an operation?

A. That is correct.

Q. if the cancer *goes* in through the bowel wall, it drops to 70 percent total cure?

A. Yes.

Q. And even if it's in the lymph nodes, there is still about a 50 to 60 percent chance of being cured with an operation?

A. 40 to 50.

Q. You don't agree with the 50 to 60 percent?

A. No.

MR. GOLDWASSER: What are you reading from, Bill?

MR. GREENE: My notes.

Q. And you would agree, doctor, that all. cancers, other than maybe cancers occurring in a disease called ulcerative colitis, which she didn't; have, all cancers in the regular

population arise in a preexisting polyp which is benign?

A. No, that's wrong. Not all.

Q. Let me finish. And starts changing towards cancer and then full blown cancer?

A. No, I disagree with that.

Q. You disagree with that?

A. Yes. Because 1 think you said all..

Q. You would agree that almost all begin with polyps, adenocarcinoma of the colon, begin with a polyp, according to the accepted thinking of- gastroenterologists?

A. I would say probably 80 percent again, 80, 85 percent.

Q. Would it be significant to you as to how much bleeding existed in Mrs. Petrilli, the quantity of blood that she had?

A. Would it be significant, the quantity of blood?

Q. Yes.

A. Really, no.

Q. And, doctor, you've testified earlier that in 1989 the standard would have been to do a colonoscopy and look at the entire

Q. And in the Sleisenger and Fordtran book, they state that, in 1983, that the accepted workup when adenornatous polyps appear in your differential is to look at the colon either radiographically or fiberoptically or both; is that correct?

A. Yes, I think you did quote that.

Q. And so their standards in 1983 are different than your standard in 1983; is that correct?

A. I think you are quoting general information. I think my standard is pretty close to Fordtran and Sleisenger and Harvey Dworken in both years, but when we talk about a particular case, I know Harvey would have probably done the same thing.

Q. Would have done the same thing what?

A. If somebody presented as this person presented.

Q. With bright red bleeding?

A. Harvey probably wouldn't have colonoscoped him. See, that's where you lose it quoting from books, because I know personally.

Q. Dr. Harvey Dworken says that bloody stools may originate from any part of the tract.

A. Harvey Dworken is a very cautious arid careful and artistic historian. I think he relies on history.

Q. Well, Francis Owens' history -- did Dr. Owens take what you consider to be a complete arid thorough history from this patient?

A. I wasn't there.

Q. Reading it, does that look to you like it's a complete and thorough. history?

A. From my own experience, what goes down on the paper and what is done in the office sometimes don't reflect --

Q. Well, doctor, in your own experience in taking a thorough history, about how long would it take you to take the history?

A. 20 minutes, in a setting like this.

Q. Assume that Dr. Owens' consultation was five minutes, Do you think that would be long enough to take a thorough history a5

colon, whereas in 1985 the standard wasn't for this case; is that correct?

A. That's correct.

Q. When did the standard change? Was it 86, 87, 88?

A. Oh, I would say, in my mind --

Q. In your opinion,

A. -- probably 87.

Q. Okay. Was there any particular impost, anything that happened in 1987, any particular advance in gastroenterology that occurred in 87 that wasn't there in 85 that would have led to a changing of the standards for colonic investigation of this kind of problem?

A. Well, I think, number one, I think the failure of the guiac testing to, as a negative, show that there were truly no cancers in the colon, or, as a positive, to show that there was truly a cancer. But I think more importantly, what I said initially, the negative, the false negative rate, became much more generally known.

Secondly, I think the air contrast barium enema came into its own population

then.

I think colonoscopy always, to some degree, varied with the aggressiveness of the person handling the case, so in my own personal philosophy, I got a little more aggressive. That's all.

And I got a little less -- I became less confident in my ability as a clinician at that: point to pick it up.

Q. Why is that?

A. Well, I just think if a hernocult test, if it's negative, I then -- when I find that; information out, that's enlightening, because I relied a lot on the negative hernocult; tests before that, and I relied a lot on the value of a sigmoidoscope examination.

Q. But you do --

A. So to put the two together, I would say back in 85 I felt very confident. As time evolved, I became less and less, and right now, you present this case to me now, there is no question, what we know, something else could he done.

Q. You would look at the whole colon?

A. Yes.

Q. What you axe saying is between 1985 and 1987, in your opinion, the standard changed?

A. I would say in 1985 I can probably recall cases just like this 1 did the same thing.

Q. Did any of your cases turn out to be people who had cancer?

A. Not that I know of. That's a worry.

Q. Doctor, bleeding is thought to be a symptom of early rather than Late colorectal cancer; isn't that correct, in general?

A. Bleeding?

Q. Yes, bleeding.

A. Left-sided colorectal, *yes.*

Q. Doctor, are you familiar with a study khat was done on 2,200 patients with rectal bleeding, was done in 1982 by Dr. Shinya, S H I N Y A? Do you know Shinya?

A. Yes.

Q. He had a lot to do with the colonoscopy, didn't he?

A. If you bent over to tie your shoes, Dr. Shinya would colonoscope you. I think that

states his philosophy.

Q. In that study of 2,200 patients presenting with rectal. bleeding, they found that five percent had bright red rectal bleeding on right-sided colon cancers.

A. I would think people who were left handed and were colonoscoped by Dr. Shinya, he would probably find the same rate.

Q. Are you familiar with that study?

A. Five percent to me is a difficult number. I don't know how highly statistically significant that is. I'm not familiar with that particular study.

Q. He found that 110 patients out of 2,200 presenting with rectal. bleeding, bright red rectal bleeding, had right-sided colon cancers.

A. Yes.

Q. That is a significant statistic, is it rnot?

A. Five percent?

Q. Yes.

A. Did he have a control group?

Q. Yes. They had a group --

A. How many were in the control?

Q. I'm just asking, that is a significant statistic, is it not?

A. It stinks, unless you give me a control group with the same figures, with zero figure.

Q. Well, doctor, in your practice, did you utilize control groups in your experience?

A. I'm not quoting the literature to make a point.

Q. I'm just saying -- if you have any literature that you want to quote, I'll be glad to look at it,

A. I got 20 years; you've got one week of reading literature.

Q. No, doctor, I don't think so. I have an expert-, also and the Literature that I have gone through is every article probably from 1971 on. If you have an article, I would like to *see* it,

MR. GOLDWASSER: We are not here to argue about it.

Q. Well, doctor, you were an expert in a lawsuit against Suburban Hospital a little while ago, were you not?

A, I'm not sure, How --

Q. Okay. The case is the Duren case, does that ring a bell, D U R E N?

A. Yes.

Q. You were an expert there, were you not?

A. I had a person run it by me, and I went and gave a deposition, yes.

Q. You gave a deposition, did you not?

A. Yes.

Q. You also wrote letters, did you not?

A. I must have, yes.

Q. And you felt it was important at that time that; you have literature to support your opinion, did you not?

A. I'm not sure.

MR. GOLDWASSER: Why don't you save it for trial, Bill. Why give it all away now.

MR. GREEME: Let me do my deposition.

MR. GOLDWASSER: Do it, do it. I mean, you take all the intrigue out of it.

MR. GREENE: Maybe and maybe not.

Q Didn't you think it was important

at that. time that you find literature to support your opinion that Mr. Duren would have died even if there was malpractice?

A. I really don't recall,

Q. Do you know who Pat Murphy is?

A. Yes, I do.

Q. Didn't you tell Pat that you could not testify unless you had literature to support your opinion?

A. I don't remember that.

Q. Now, doctor, would you agree that a consult over rectal bleeding is the most common presenting symptom that can be attributed to colon polyps?

A. Yes.

MR. GOLDWASSER: What book are you reading from?

A. Fordtran and Sleisenger, old edition.

MR. GREENE: The 1983, because this happened in 1985.

MR. GOLDWASSER: All right.

Q. And the accepted workup in 1983 when colon polyps, colorectal polyps, appeared in your differential diagnosis was to do either

a colonoscopy or a barium enema; isn't that correct? Isn't that the accepted workup?

A. If you were -- if you had a strong suspicion of colon polyps, yes

Q. What if it appears in your differential diagnosis, doctor?

A. It would have to depend on how high up in the differential it was. Certainly that could be criticized. LE one family member had colon polyps, that. would be in a differential, and yet you wouldn't colonoscope every family membei.

MR. GREENE: Would you read that back, please?

(Record read.)

Q. Doctor, I'm reading you from the Sleisenger book. That was a book that you would consider in 1983 to be an authoritative source of information?

A. Yes.

Q. Would you agree that in the differential diagnosis of bright red rectal.. bleeding -- she did have bright red rectal.. bleeding, did she not, doctor?

A. Yes.

aggressive search for the cancer must be done, including barium enema and colonoscopy, in 83?

A. Out of context, yes. Broad category, rectal bleeding, yes, but I think we have been over this in the past ---

Q. I understand what you are saying.

-- from a clinical approach.

Q. You would agree that rectal bleeding is one of the leading symptoms of colon cancer?

A. Yes.

Q. Now, doctor, in 1983 in the Fordtran book, they are saying here that formerly one or more stool samples were tested in patients without dietary restrictions and without quality control of guiac reagents. This approach had an unacceptably high rate of false positives and false negatives; isn't that correct? Would you agree with that in 19833

A. I think the hernocult test has gone through so many variations and changes that I -- 1983, that would be -- sound about right, yes.

Q. Well, your 1987 benchmark for a change in what you considered the standard

practice relied upon information that hemocult tests were not as accurate as they should have been or as they were presumed to be; is that correct?

A. That they were relied on the fact that hemocult tests had a much higher false negative rate than once considered.

Q. The standard that we are talking about is not the standard for a doctor; it's the standard for a board certified gastroenterologist?

A. That's correct.

Q. And you would agree that even by 1983 the Sleisenger book was discussing the perils of doing one stool guiac sample as opposed to a regimen; is that correct?

A. Correct.

Q. Now, the second reason that you said the standard changed had to do with colonoscopies being in more widespread use?

A. No. No. I think more aggressively used. It's always been available.

Q. Doctor, in 1983, in the Sleisenger book., it says under the hemorrhoid section that sigmoidoscopy is mandatory to detect neoplastic

or inflammatory disease that may be responsible for symptoms.

Would you agree with that?

A. Definitely.

Q. It goes on to say, and barium enema x-rays are advocated in all patients over age 40 for the same reason.

Would you agree with that?

A. No, not really.

Q. This was 1983.

A. Yes, and I think there was always --

Q. It goes on to say, it is important that. rectal bleeding not be attributed to hemorrhoids unless other, more serious disease is excluded.

Would you agree with that?

A. I would think in the -- yes, but, again, sigmoidoscopy is a very important tool here in doing that very thing.

Q. But sigmoidoscopy will only pick up probably 50 percent of the lesions, colorectal cancer lesions; correct?

A" No.

Q. You don't agree with that 50

percent figure?

A. No. Arid I don't agree -- we are talking about a subgroup of colorectal cancers that present with bright red blood. I would say the sigmoidoscopy would pick up over 80 and probably well into 90 percent.

Q. But when you are working up a patient to exclude carcinoma --

A. Who presents with bright red blood.

Q. -- you have to rule it out, don't you, doctor?

A. You do your best to rule it out,

Q. Can you rule it out, doctor, without; looking at the entire colon? Can you really rule it out?

A. In 1989, I don't think you can, no.

Q. The tools that were available to you to rule out cancer of the colon in 1989 were all available in 1985, were they not?

A. But the attitudes weren't.

Q. Dr. Harvey Dworken was the guy that trained you; correct?

A. One of them.

Q. Someone whose opinion you respect?
A. I respect Harvey, I respect Francis Owens, too.
Q. Harvey's book was written in 1982, was it not?
A. Yes.
MR. GOLDWASSER: What's the name of the book arid the publisher?
MR. GREENE: Gastroenterology, Harvey Dworken, Butterworth.
Q. Would you agree that bloody stools may originate from lesions at any level of the tract,?
A. What do you mean by bloody?
Q. Stools with blood on them.
A. No, I don't agree with that.
Q. Would you agree, doctor, that diagnosis of adenomatous polyps of the colon is by barium enema and endoscopy in 1982?
A. I have to inform you that flexible sigmoidoscopy is endoscopy.
Q. I understand that, doctor. You are not informing me of anything.
But would you agree with that statement?

A. I wanted to make sure you knew that.

Q. I'm trying to learn, doctor, and maybe you can try to help me learn, but would you agree that diagnosis of adenomatous polyps of the colon in 1982 is by barium enema and endoscopy?

A. Yes.

Q. Did Mrs. Petrilli have a barium enema study in 1985?

A. No.

Q. And if adenomatous polyps appeared in Dr. Owens' differential, he would have been obligated to give her a barium enema, would he not, to rule it out?

MR. GOLUWASSER: Objection. You may answer.

A, I don't -- I have all kinds of trouble with that question. I have a bias against barium enemas being sensitive to pick them up, number one.

Q. You would rather use a colonoscopy to pick up a polyp?

A. I would rather use an air contrast barium enema or a colonoscopy.

Q. Could you rule out adenomatous polyps without, once it appears in your differential, without doing a study of the colon that allowed you to look at the entire colon?

MR. GOLDWASSER: Objection.

A. My accuracy of ruling out adenomatous polyp that was giving bright red blood in the stool. would probably be close to 90 percent with a flexible sigmoidoscope.

Q. You just leave the other ten percent, doctor?

A. If the stool is guiac negative, I would trave then.

Q. You would have let it go on one --

A. Told her to come back when it was bleeding. I had done that with people.

Q. Well, I'm not --

A. What can I say?

Q. I'm not inquiring whether you did something at; that time that you should have done or shouldn't have done.

I'm only asking you: In 1982, it was advocated that for a suspicion of adenomatous polyps, if it appears in your

differential, that the way to work it up is by looking at the colon, the entire colon; isn't that correct?

A. Depends where you think the adenomatous polyp is. If you think it's left sided, no, you do a flexible sigmoidoscope.

Q. But you still can't rule it out without looking at the entire colon, can you?

A. No.

Q. And Dr. Owens did rule it out, and he didn't look at the entire colon; isn't that correct?

A. I'm not sure -- see, you are giving information.

Q. Assuming it was in his differential.

A. I don't know what he said.

Q. Assuming it was in his differential.

A. Assuming it was in his differential -- I would have to hear, really, his deposition, actually.

Q. Assuming it was in his differential, could he have ruled out adenomatous polyps without looking at the

entire colon?

MR. GOLDWASSER: Objection.

A. I would like to see his deposition. I would like to see how the question was phrased to him and how he answered it.

Q. Assuming, doctor, that it was in his differential, that's all I'm asking, assuming it was in his differential --

A. I don't feel comfortable answering the question as you put it.

Q. Because you don't think that I'm accurately portraying what he testified to?

MR. GOLDWASSER: I don't think he --

A. I think you have an ax to grind, arid I am trying to at least tell you haw I feel about left-sided versus right-sided lesions.

I'm also telling you how I felt in 1985 about the hernocult test. and how I felt in 1985 about sigmoidoscopy as a sensitive test fur finding lesions that present as blood on the surface of the stool.

Q. Doctor, if your --

A. I hope you got all that.

Q. I got all that, If your sigmoidoscopy is negative, do you just leave it, or do you go on and look at the rest of the colon in searching Ear adenomatous polyps?

A. Right now I have no problem answering that question. In 1985, if the stool was negative, I'm telling you, I've had people I told to come back if they had blood again.

Q. Right now you look at the entire colon in searching for adenomatous polyps; correct:, in this case?

MR. GOLDWASSER: Me's already said that.

A. Yes.

Q. And in 1982, Dr. Dworken was recommending in his book that you look at the entire colon in searching for adenomatous polyps; correct?

A. In what setting?

Q. The setting where it appears in your differential.

A. I mean --

Q. You can't answer that. question?

A. I think it's a vague question, yes.

referenced by this record that you see in front of you of this history?

MR. GOLDWASSER: Is that what it was, five minutes?

MR. GREENE: That's what his testimony is, yes, five minutes.

MR. GOLDWASSER: He testified to that? You can answer, if you don't think it's long enough.

A. I don't think it's long enough.

Q. Do you see anything here about family history of cancer, colon cancer?

A. No.

Q. Would you want to know that when you are taking the history of this patient?

A. In 1989 I would.

Q. In 1985, would you want to know about, a family history?

A. Pilot, as strongly as I do now. I think all that history on family history and colon polyps and colon cancers are from late 1985, 1986.

Q. 1985, you would have expected a more thorough history; is that correct?

A. If it were only five minutes, I

would expect him to spend a little longer.

Q. You would have expected a note that would have at least referenced family history, would you not?

A. Not necessarily in 1985, no.

Q. Doctor, do you do sigmoidoscopies?

A. Yes.

Q. Could sigmoidoscopies pick up internal hemorrhoids?

A. Yes, they do,

Q. You would expect on a sigmoidoscopy, if someone had an internal hemorrhoid, that that would be reported, wouldn't you?

A. Should be.

Q. The sigmoidoscopy that was done on July the 16th, 1985, does that show any internal hemorrhoid?

A. No internal hemorrhoids, and what does that say, staining?

MR. GOLDWASSER: That says digital-exam.

Q. I'm asking you the next note.

A. within normal- limits.

Q. It does not show an internal

hemorrhoid, does it, doctor?

A. No. No polyps I think is what they are talking about, but specifically no internal hemorrhoids, right. It was within normal limits.

Q. What's the most accurate tool, referencing 1985, what was the most accurate tool at your disposal to rule in or rule out the presence of either adenomatous polyps or colorectal neoplasms in a patient?

A. Endoscopy.

Q. And that would be a cofonoscopy, would it riot:?

A. No. It would either be a flexible sigmoidoscopy or colonoscopy.

Q. What was the most effective tool to rule in or out right-sided lesions? It's not sigmoidoscopy?

A. I'm not sure that was in the differential.

Q. Colorectal cancer?

A. Didn't you just say right-sided lesion?

Q. I'm only asking you what is the most effective.

MR. GOLDWASSER: He's talking about in the abstract.

Q. What was the most effective tool available to you to rule in or out colorectal cancer in 1985?

A. Colonoscopy, endoscopy.

Q. Doctor, this is a representation of the colon. Is that relatively accurate, as far as it yoes?

A. Yes.

Q. Can you take a pen, I'm going to label this as Plaintiff's Exhibit: A, Deposition Exhibit A, and would you mark for me how far a 30 centimeter --

MR. GOLDWASSER: 35. It was 35 centimeters.

Q. On your report, doctor, you said that. the exam was negative to 30 centimeters. J think Mr. Goldwasser is right. I think it was to 35 centimeters.

Could you point" out to me where 35 centimeters is?

A. (Indicating.)

Q. So your testimony is today this -- you've made a double line with a pen; correct?

A. Yes.

Q. Would you initial that double line?

A. Let me just say one other thing here. Let me just -- am I allowed to make a --

Q. Do whatever you want to.

A. Good. I'll put from here to here (indicating) far 35 centimeters, depending on how well they can straighten out that line.

Q. And in doing that, you are looking at approximately one-third of the colon; correct?

Yes.

Q. We have the other two-thirds of the colon unexplored and unexamined; is that correct?

A. Yes.

Q. And you are assuming that the bright, red blood the patient reports to you is coming from that one-third of the colon and not from the other two-thirds; isn't that correct?

A. Yes.

Q. Now, doctor, as to colonoscopy, you state in your correspondence that colonoscopy as an exam is dangerous. An I taking that out

of context?

A. It can be dangerous.

Q. What's the complication rate for colonoscopy?

A. One per thousand cases of perforation, one per thousand cases of bleeding.

Q. And --

A. And let's not forget; the anesthetic complication, too.

Q. In your experience, what's your complication rate?

A. Well, until last month I never had a perforation, but I did with a polypectomy.

Bleeding, maybe three cases.

Q. Out of how many?

A. Well, since 1970.

Q. You have been doing them since 1970?

A. Yes.

Q. About how many colonoscopies have you done?

A. A couple thousand, probably.

Q. So you have found it to be a relatively safe procedure, have you not,

doctor?

A. I think there is a risk.

Q. I understand that, There is a risk in getting up in the morning, but hasn't it been a relatively safe procedure, doctor?

A. Tell me how you felt during your colonoscopy times two.

Q. I didn't feel a damn thing.

A. Were you worried going into them, were you worried about perforation or bleeding?

Q. I was more worried about what was bleeding than that. Let's get back.

It has been described in the literature as a relatively safe procedure, hasn't it, doctor?

A. No. I think it has a risk of one per thousand cases.

Q. I'm only asking you, it's been described in the literature as a relatively safe procedure, hasn't. it?

A. I think more accurate is when you say one per thousand cases.

Q. Do you have any information whatsoever that Mrs. Petrilli would have

refused a colonoscopy if offered her?

A. No, I don't.

Q. Complication rate is about one in a thousand?

A. Yes.

Q. What's the mortality rate of that -- of a colonoscopy?

A. I would think of that one in a thousand probably a fourth die or a fifth.

Q. Do you know if anyone has ever died from a colonoscopy at the Cleveland Clinic?

A. I presume they have,

Q. You don't know that for a fact, do you?

MR. GOLDWASSER: The fact is you don't know?

A. I don't know. I would presume. You do enough of them, somebody is going to die.

Q. Doctor, are you familiar with any of the general reference books on cancer?

A. Yes

Q. Is DiVita one of the books you are familiar with?

A. Yes.

Q. That's a generally accepted authority that doctors look to?

A. Yes, I think it's an accepted authority.

Q. Okay. Doctor, in DiVita, it says hemorrhoidal bleeding should always be a diagnosis of exclusion. Would you agree with that?

A. Yes.

Q. It says, all patients with rectal bleeding should be evaluated. You would agree with that?

A. I think that's true.

Q. If the blood is minimal and bright red in appearance, is located only on the toilet paper and is associated with normal color stool, a sigmoidoscopy may suffice. Would you agree with that?

A. Yes.

Q. All other patients should undergo sigmoidoscopy and barium enema examination or colonoscopy. Would you agree with that?

A. Yes.

Q. Did Mrs. Petrilli have normal colored stool?

A. Yes.

Q. You would consider stool with blood on the surface of it normal color stool?

A. Yes.

Q. Is that the stools you have in the morning, doctor?

MR. GOLDWASSER: Oh, come on, Sill..

Q. Stools with blood on the surface of them?

A. I have normal color stools.

Q. So stool with blood on them is a normal- colored stool; is that what you are saying:,

A. Yes, that's correct, Now, let me --

Q. You can -- fine.

MR. GOLDWASSER: Bill, I would like that article. Would you read that into the record?

MR. GREENE: I just did.

MR. GQLDWASSER: Did you identify the entire article?

MR. GREENE: I'm going to read it in.

MR. GOLDWASSER: Let me see it. I haven't found this one before. That's good. This is DiVita, Jr.'s book.

MR. GREENE: Yes.

MR. GOLDWASSER: Lippencott is the publisher. What's the publication date of this? Do we have it here?

MR. GREENE: That's brand new.

THE WITNESS: Third edition.

MR. GOLDWASSER: Is it new'?

MR. GREENE: It's brand new. There are similar --

MR. GOLDWASSER: And you were reporting from page 903.

MR. GREENE: Yes, you are right.

Q. Doctor, would you agree in discussing right colon cancer that bleeding may he acute and most commonly appears as red blood mixed with stool?

A. Acute bleeding is bright red blood, is bright red blood coming out in a gush with stool mixed in. That's my idea of an acute bleed.

Q. When you say dark blood from a right sided lesion, it's usually secondary to

divert.iculi bleeding?

A. I really don't discern the two. If I seed maroon stool, i.f I see dark blood, I think it's right-sided. I don't know if it's divert,icular cancer.

Q. Why do you think blood appearing on the surface of the stool is normal colored stool?

A. I think the blood is red; I think the stool is brown. I think that's blood on the surface.

Q. You think that they are saying that normal-appearing stool has blood on it?

A. Yes.

Q. Oh, I see. So when they say that if it appears on the toilet; paper only, they are not talking about if it appears on the stool itself? Is that your testimony?

A. No. It appears on both.

Q. Their quote is if it appears only on the toilet paper.

A. Well, only on toilet paper, fine. I think if the -- I think I know what he means.

Q. Okay. Thank you, doctor. I'm glad

you do.

A. Apparently you didn't.

Q. Would you agree, doctor, that rectal bleeding should never he attributed to hemorrhoids, especially in older individuals, unless a malignancy has been ruled out by barium enema arid proctoid sigmoidoscopy? Would you agree with that?

A. Older individual, rectal bleeding --

Q. Rectal bleeding.

A. Yes, I would agree with that,

Q. She had rectal bleeding, didn't she, doctor?

n. She had blood on the surface of her stool, that's rectal. bleeding, but I think you have to define --

Q. I just want to know, she had rectal bleeding, didn't she?

A. Yes.

Q. This appears in Harrison's Principles of Internal Medicine, and this is a 1983 edition.

A. Yes.

Q. Her malignancy was never ruled out

by a barium enema, was it, doctor?

A. Barium enema in 1983 was not a very sensitive test.

Q. Rut. it was never utilized; there was no test; here utilized at all to rule out a right-sided lesion; correct?

A. No, No.

Q. Is Harrison's Internal Medicine a book that you utilize in your practice?

A. No.

Q. It's on your library shelves, though, isn't it, your library shelves of where you are at now?

A. I don't use it for gastroenterology. I think it's very weak.

Q. Would you agree, .in regard to internal hemorrhoids, that such lesions are very common and should not be regarded as the cause of rectal bleeding?

A, Yes.

Q. You would agree that rectal bleeding is a symptom that requires investigation and cannot be attributed to a simple cause; there are multiple other causes that create bleeding, and it should not be

assumed to be occurring from something simple like a hemorrhoid?

A. Yes.

Q. Arid you would agree that bright red blood can come from the stomach?

A. No.

Q. Okay.

A. Not like this. Not bright red blood in the stool.

Q. Come from the small intestine?

A. Bright red blood, I think if you are talking about a hemorrhage, big time gush of blood, it can come from anywhere in the GI tract, not a string of --

Q. A hemorrhage is a bleed, is it not, doctor?

A. We are talking -- well, sure, yes.

Q. A hemorrhage is a bleed; right?

A. Fine.

Q. Do you know how much she bled on Memorial Day 1985?

A. Are we speaking generalities or this case?

Q. This case, do you know how much --

A. Her hematocrit was normal. She

didn't bleed much.

Q. May of 1985, do you know how much the woman bled?

A. No.

Q. You don't know if she had a hemorrhage then or not?

A. Whatever you say.

MR. GOLDWASSER: No, we don't know.

Q. We don't know, do we?

A. No.

Q. When did you begin to do stool guiac tests using three specimens -- two specimens on three successive days?

A. I would have to answer that i.n two ways. In screening large populations probably like people coming into the office for any reason, in the 1980's --

Q. Prior to 85?

A. Prior to 85, *yes.*

Q. Was there any reason with this patient; not to at least screen her stool?

A. No.

Q. You would agree that Dr. Owens' workup of this patient, he did not look at the

entire left side of the colon?

A. Probably didn't.

Q. Doctor, is blood on the toilet paper, in this patient, the fact that it was on the toilet paper, proof positive of a lower rectal lesion?

A. No. It strongly suggested it, but it wasn't proof positive.

Q. It would have been more impressive to you for that rationale if the blood was on the toilet paper but not on the stool?

A. No. No. Usually you get -- I think you can make the corollary of your initial question, is blood streaking the stool proof positive of a rectal lesion, and it isn't, but, again, it has a high probability.

Q. What you are doing is you are getting a clinical impression, hut you are not able to rule out a lesion higher up in the tract?

A. Usually within the reach of a Sigmoidoscope.

Q. But still even though all of that is true, you can't rule it out unless you look higher and you look at the entire colon? You

found that out, haven't you, doctor?

A. I found out that blood streaking the stool with blood on the tissue, 90, 95 percent of the time, comes from something khat:'s within the reach of the sigmoidoscope.

Q. Do you have any indication in this record that my client, Virginia Petrilli, was interested in gambling?

MR. GOLDWASSER: What?

A. I don't think this is gambling. I think probabilities, I think if you are anywhere --

MR. GREENE: I strike the question.

MR. GOLDWASSER: Yes.

Q. But you would not agree with the quote that appearance of blood on the toilet paper is proof positive of an anorectal lesion?

A. It is strongly suggestive.

Q. It's riot proof positive?

A. I would do a sigmoidoscopy to make sure.

Q. Even that won't make sure?

A. 95 percent of the time it will.

Q. Five percent of the time is the five percent that they are talking about in Lancet's article, isn't it, doctor?

A. No, it isn't, unless you have a control group.

Q. Doctor, do you know of anywhere in the literature that says that you can rule out a right-sided lesion based on a report of a patient having bright red blood in her stool?

A. No.

Q. Now, if Virginia had just come in and seen you in 1985 because she heard that you were a very fine doctor, at 61 years of age, having never had a colon workup, you would have given her a stool guiac test and a sigmoidoscopy, would you riot, as part of her workup?

A. As the way she presented, yes.

Q. Arid you would have utilized a stool guiac: test?

A. I would have done a rectal exam and --

Q. As recommended by the ACS?

A. I would have done a stool guiac. I don't know if I would have given her the

sigmoidoscopy then or not.

Q. Once again, doctor, on Memorial Day of 1985, given the history that you have of this patient, you don't know how much she bled; is that. correct, quantity?

MR. GOLDWASSER: Didn't we answer that question?

A. I would assume it wasn't a very large quantity.

Q. You don't know the quantity, do you, doctor?

A. I don't know the quantity.

Q. Now, as to colorectal polyps and cancer, some bleed a little; is that correct?

A. Some bleed a little.

Q. Some bleed a lot?

A. Some bleed a lot.

Q. Some of the blood is visible?

A. Some is visible.

Q. Some is occult?

A. That's correct.

Q. Some bleed and stop?

A. Yes, I guess they do.

Q. Some keep on bleeding?

Yes.

Q. And this is a major killer in our population, second leading cause of death of women her age?

A. Colorectal cancer, not polyps?

Q. Yes, colorectal cancer.

A. That's correct.

Q. Arid one of the reasons that. you do -- one of the strong reasons why you do surveillance is to find these cancers while they are polyps and interrupt the polyp/cancer progress; is that correct?

A. That's correct.

Q. Would you agree that any neaplastic polyp, such as an adenomatous polyp, should be considered a potentially malignant Lesion?

A. Probably.

Q. Would you agree that colorectal cancer is silent in its early development, the most common early presentation is bleeding resulting in positive stools for occult blood or gross rectal bleeding?

A. That's right.

Q. Would you agree that since early colorectal cancer produces no symptoms, since many of the symptoms of colorectal cancer are

nonspecific, aggressive efforts at the incept-ion are essential?

A. That sounds good, yes.

Q. That would be true in 1985, would it not, doctor?

A. More so in 85. More *so* in 89 than a5.

Q. Still true in 85?

A. Still true.

Q. Would you agree, doctor, that the passage of bright red blood per the rectum is most often seen with lesions of the rectosigmoid but; can be seen with cancer anywhere in the colon?

A. No.

Q. And, doctor, it's your testimony that the information about the 50 percent false negative rate of a single guiac test was not generally available to board certified gastroenterologists in 1985?

A. I think we are talking two things here. The false negative rate of your three slide tests is *50* percent,

Q. That's your testimony? Was that known in 1985?

No.

The false negative rate of doing a stool guiac with one sample being a large false negative rate in the 50 percent area was well known in 1985, was it not, among board certified gastroenterologists?

A. It was known that a sinyle -- well, yes.

Q. It wasn't a recommended test?

A. Right.

Q. Okay.

A. For screening of the population.

Q. It wasn't a recommended test to see if there was blood in the stool.. or not?

A, The whole context of that slide was to screen for colon cancer of population.

Q. I understand that, doctor. I'm just saying: It was not a recommended test in 1985 to rule out occult blood in the stool?

A. Probably not.

Q. Okay.

MR. GREENE: Thank you.

(Deposition concluded at 7:10 p.m.)

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CERTIFICATE

The State of Ohio,)

SS:

County of Cuyahoga.)

I, Karen M. Patterson, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, KEVIN T. GERACI, M.D., was by me first duly sworn to testify 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 31st day of May, 1990.

Karen M. Patterson

Karen M. Patterson, Notary Public within and for the State of Ohio

My commission expires September 13, 1994.

LAWYER'S NOTES

PAGE	LINE	