

1 STATE OF OHIO)
) SS: IN THE COURT OF COMMON PLEAS
 2 MAHONING COUNTY)

3
 4 CASE NO. 96 CV 2055
 5
 6

7 DOROTHY A. GONDA, Individually)
 and as Administratrix of the)
 8 Estate of David Paul Gonda,)
 Deceased)

9 Plaintiff)

DEPOSITION

10 VS.)

OF

11 HM HEALTH SERVICES, ET AL)

ROBERT D. HOFFMAN, II, M.

12 Defendants)
 13
 14

15 DEPOSITION taken before me, Debra M. Moore, a Notary
 16 Public within and for the State of Ohio, on the 8th Day of
 17 December, A.D., 1998, pursuant to agreement and at the tim
 18 and place therein specified, to be used pursuant to the
 19 Rules of Civil Procedure or by agreement of counsel in the
 20 above cause of action, pending in the Court of Common
 21 Pleas, within and for the County of Mahoning, State of
 22 Ohio.
 23
 24
 25

COPY

APPEARANCES

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PLAINTIFF'S EXHIBITS INTRODUCED: NONE

DEFENDANT'S EXHIBITS INTRODUCED:

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STIPULATIONS

It is stipulated and agreed by and between counsel for the parties hereto that this deposition may be taken at this time, 10:00 a.m., December 8, 1998, in the offices of University Hospitals of Cleveland, 2085 Adelbert Road, Cleveland, Ohio.

It is further stipulated and agreed by and between counsel that the deposition may be taken in shorthand by Debra M. Moore, a Notary Public within and for the State of Ohio, and may be by her transcribed with the use of computer-assisted transcription; that the witness will read and sign the finished transcript of his deposition.

1 WHEREUPON,
2 ROBERT D. HOFFMAN, II, M.D.,
3 of lawful age, being by me first duly
4 sworn to testify the truth, the whole
5 truth, and nothing but the truth, as
6 hereinafter certified, deposes and
7 says as follows:

8 CROSS EXAMINATION:

9 By Mr. Travers

10 Q Good morning, Dr. Hoffman. My name is
11 Tom Travers. I'm the attorney in this case for Dr. Ruiz,
12 and we are here in Cleveland today to conduct your
13 deposition. This is simply an opportunity for us to ask
14 questions of you to make sure that we're fully informed of
15 the opinions that you hold in this case and the rationale
16 supporting those opinions in anticipation of the trial of
17 this lawsuit.

18 I have a few suggestions for ground rules this
19 morning, if I may. First of all, I would ask if you're
20 going to answer questions yes or no, you say yes or no,
21 rather than uh-huh or huh-uh. That helps the court
22 reporter get an accurate transcript back.

23 Secondly, it's important that you understand my
24 questions. If you answer them, I'm going to assume you
25 understood what I was asking. If you don't, please make

1 sure that I'm aware of that, and I'll be happy to address
2 whatever problem that you're experiencing.

3 I view this as an informal proceeding, If you need to
4 take a break to use the restroom or answer a page or get a
5 drink of water or talk to the lawyers for the Gonda family,
6 for whatever reason, please just identify that to me, and
7 I'll be happy to address your concern. Those ground rules
8 are okay with you today?

9 A Yes, they are.

10 Q Would you tell me your full name, please?

11 A Robert Hoffman.

12 Q As I understand it from your CV, Doctor,
13 you presently are the Director of Autopsy Pathology here at
14 UH in Cleveland; correct?

15 A That's correct.

16 Q And you've held that position since 1992?

17 A That's correct.

18 Q How many other physicians are on staff in
19 the Pathology Department here at the hospital?

20 A There are about 20 practicing
21 pathologists in the department.

22 Q And it's also a teaching facility for
23 pathologists?

24 A Yes, it is. We have a pathology
25 residency training program that I direct.

1 Q I have previously been given your CV, but
2 I see that this one's dated 12/8/98, so this must be a
3 brand new one. I've not had a chance to look through it
4 here this morning. I assume that this is complete and
5 accurate?

6 A It is.

7 Q As of today, I guess?

8 A Yes.

9 Q I want to be clear at the outset, Doctor,
10 how you view your role in this case. Are you here as an
11 expert witness to lend your expertise to some of the
12 difficult medical issues, or are you here as an advocate
13 for the Gonda family to assist in the presentation of their
14 claim?

15 A I believe my role is to clarify the
16 autopsy findings, which is the area of my expertise.

17 Q As opposed to being an advocate for their
18 case, as I understand what you're telling me; correct?

19 A I'm here to tell you the truth as I see
20 it.

21 Q Okay. The reason I ask, primarily, is
22 because I view a distinction here. If, as we proceed, if
23 you're serving in the role of an expert, I'm going to ask
24 that you just answer my questions, rather than feel
25 compelled to explain why they're stupid questions or

1 misleading, which I would view more in the role of an
2 advocate. Do you understand the distinction I'm trying to
3 make?

4 A Not particularly.

5 Q Okay.

6 MR. RUF: He's just here to answer
7 your questions.

8 Q And I guess that's all I'm hopeful that
9 we will do today. That's your plan; correct?

10 A That's correct.

11 Q Okay. Now, do you claim any particular
12 specialized expertise in the pathological diagnosis of
13 infective endocarditis?

14 A None other than would be held by a
15 competent pathologist who performs a number of autopsy
16 examinations. I think that's a reasonable degree of
17 expertise. I see a number of cases of infective
18 endocarditis every year.

19 Q I think you've answered my question, but
20 the distinction I'm trying to make is if we went to one of
21 the other 20 pathologists here on staff at University
22 Hospitals, and assuming that they have a reasonable degree
23 of expertise, you don't claim to have more specialized
24 training or understanding in the identification of
25 infective endocarditis than they may?

1 A I see many more hearts than essentially
2 all of them, and I do many more autopsy examinations than
3 any of them, as you're probably aware. Outside of the
4 setting of transplantation surgery, the diagnosis of
5 infective endocarditis, you know, in whole-heart specimens
6 is an autopsy procedure.

7 Q Do you have any particularized training
8 in studying hearts at autopsy that a typical pathologist
9 may not have?

10 A Yes. I mean, I have brought into place
11 in our autopsy service a number of procedures that I
12 learned when I was a trainee at the Johns Hopkins
13 University, mostly involved with the diagnosis of coronary
14 artery disease. These are, I think, specialized procedures
15 and techniques that I've brought into play.

16 Q Do you know whether you have a higher
17 degree of expertise than the staff pathologists at
18 Cleveland Clinic?

19 A I do not know specifically the staff
20 pathologists that you're referring to.

21 Q Well, do you know any of the individuals
22 whose names appear on Mr. Gonda's autopsy report?

23 A No, I do not.

24 Q Without knowing their degree of education
25 or expertise, would you agree that you don't claim to have

1 a higher degree of expertise than they may?

2 MR. RUF: Objection.

3 A I wouldn't agree to that. I don't know
4 who these people are. If they walk in this room, I
5 wouldn't know them.

6 Q Well, I guess that's my point. That's
7 why I'm suggesting you don't claim to have a higher degree
8 of expertise than they do, because you don't know their
9 expertise; correct?

10 MR. RUF: Objection.

11 A I reiterate, I don't know who these
12 people are, and I don't want to put myself above or below
13 them on that basis.

14 Q That's all I'm asking, honest. I have
15 not reviewed all of the publications that are included here
16 on the updated CV which has been provided to me. Can you
17 tell me whether any of those specifically deal with the
18 identification of bacterial endocarditis on autopsy?

19 a No, none of them do.

20 Q Any of your other presentations or
21 abstracts?

22 A No, I have not published any
23 presentations or abstracts related to this topic

24 Q I would like to spend a moment to make
25 sure that I am clear on the things that you have done and

1 reviewed in order to formulate the opinions which you hold
2 in this case.

3 A Okay.

4 Q First of all, is it true that you
5 reviewed no gross specimens from Mr. Gonda's autopsy?

6 A I reviewed some photographs of gross
7 specimens from Mr. Gonda's autopsy.

8 Q But the actual specimens themselves
9 you've never seen, certainly?

10 A No, I have not.

11 Q Do you hold any importance to actual
12 review of the gross specimen in order to render a
13 completely informed opinion?

14 A I'm not sure I understand that question.

15 Q Well, in order for a pathologist to reach
16 an accurate conclusion in his report, do you believe that
17 it is advantageous to have had the opportunity to review
18 the gross specimens?

19 A It would have been an advantage to have
20 been able to do that, but I believe that the materials that
21 I had to examine were adequate for the diagnoses that I
22 reached.

23 Q Okay. Let's identify what those are, if
24 we may. Are you talking about photographs of gross
25 specimens, as opposed to the individual microscopic slides

1 identified in your report?

2 A That is correct.

3 Q Do you have those with you today?

4 A I do not, no.

5 Q Do you have a recollection of what
6 photographs you have viewed?

7 A Yes, I've seen a photograph of a
8 cross-section of the fixed heart and a photograph of a
9 cross-section of the unfixed heart and a photograph of a
10 section of one of the lungs.

11 Q Do you still have those in your
12 possession?

13 A I do, yes.

14 Q I assume that the book you have in front
15 of you there, then, is not all of the materials which you
16 have reviewed in this case?

17 A That is correct.

18 Q I'm going to ask to see what you have
19 here in a moment, but before doing so, can you tell me what
20 else you have looked at or reviewed not included in the
21 materials that you have brought with you to the deposition
22 today?

23 A Mr. Malik sent me a videotape of a
24 transesophageal echocardiogram, which was of very little
25 use to me. I can see that there's something there in the

1 chamber of the heart, but I am not an expert in performing
2 those diagnoses, so that was of very little importance to
3 me. I have done some library research on this case. And
4 then these materials here would, I think, be pretty much
5 the extent of it.

6 Q It's not clear to me from my review of
7 your report, and I don't have personal knowledge, do you
8 know whether the original slides that you reviewed when you
9 authored your first report were copies of the slides in
10 existence at the Clinic, or were they new cuts made from
11 the blocks specifically for your review?

12 A I believe you just described the same
13 thing twice. They were copies that were made for me for my
14 review, but I also did go to the Cleveland Clinic and
15 examine the original slides that were on file.

16 Q Okay. So you have seen both?

17 A Yes. And I've also had some recut slides
18 made that I've had some stains performed on.

19 Q And those are the slides identified as
20 reviewed by you in your supplementary report?

21 A Yes, correct.

22 Q Can you identify for me any important
23 distinctions between the slides that are on file at the
24 Cleveland Clinic and those which were cut for your review?

25 A No, I believe that the copies that I had

1 to review were reasonable and accurate replicas of the
2 original slides at the Cleveland Clinic.

3 Q I apologize, Doctor, if I'm not following
4 you. You went to the Cleveland Clinic and looked at their
5 original slides?

6 A That's correct.

7 Q And there was then a set of their
8 original slides reproduced and provided to you?

9 A That's correct.

10 Q But other than those recuts that were
11 made subsequent to your original report, were there any
12 other cuts made from the block that you reviewed or any of
13 the blocks that were not part of the materials that would
14 have been reviewed by the physicians at the Cleveland
15 Clinic?

16 A I had some unstained sections of a couple
17 of the slides made and sent to me here, which I had stained
18 in our laboratory. And, you know, those specific slides
19 were not available to the doctors at the Cleveland Clinic.

20 Q And this is the last batch of slides that
21 formed the basis of your supplementary report?

22 A That's correct.

23 Q But at the time you dictated your
24 original report, the only things that you had seen would be
25 identical or copies of the materials that were available to

1 the clinicians at the Clinic?

2 A That's correct.

3 Q Okay. Have you spoken to any of your
4 colleagues concerning the issues presented in this case?

5 A Yes, I have.

6 Q Have you shown the slides to other
7 members of the department here for their opinions?

8 A I don't believe I have, no.

9 Q With whom have you spoken here from the
10 department about this case?

11 A I have spoken with Dr. Jacobs in the
12 department, who trained in Africa. And with -- it's Gretta
13 Jacobs. And also with her husband, Michael Jacobs, who is
14 a microbiologist, both of them in the department.

15 Q And what was the purpose of your
16 conversation with them?

17 A Asking if they had ever been exposed to
18 cases of endomyocardial fibrosis when they were practicing
19 in Africa.

20 Q Had they?

21 A They expressed some doubt about that as a
22 diagnostic entity, but they had heard of it, certainly.

23 Q Was any information provided to you by
24 either Dr. Jacob important in the conclusions which you
25 have reached in this case?

1 A Not at all.

2 Q Have you spoken with any of your other
3 colleagues?

4 A No, I don't think so.

5 Q You mentioned that you had done some
6 review of medical literature?

7 A Yes.

8 Q Can you tell me, first of all, what you
9 reviewed?

10 A Well, the usual procedure to begin a
11 medical review is to look at the literature databases, and
12 in this particular case I would have looked at
13 endomyocardial fibrosis to find out what the most recent
14 papers were on the topic, to review recent papers or recent
15 reviews on infective endocarditis, particularly germane to
16 mural endocarditis as we're seeing in this case.

17 Q This is a computerized literature search?

18 A Yes. The National Library of Medicine
19 runs a very thorough, complete system called Medline, which
20 is accessible, really, to everybody. And you can get lots
21 of literature that way.

22 Q Did you make copies of any of the journal
23 articles that were identified in your search?

24 A Yes.

25 Q Do you have those with you today?

1 A I do not.

2 Q Were any of those important in assisting
3 you to reach the conclusions that you have authored in
4 either of your reports?

5 A They were, particularly the ones on
6 endomyocardial fibrosis. I needed a basis against which to
7 compare the observations that I was making when I was
8 looking at the materials from the Gonda case in order to
9 know if this even came close to remotely resembling the
10 diagnostic criteria that are used.

11 Q Do you have any recollection of what
12 journal articles you've reviewed in that regard?

13 A I have several. I mean, if it becomes
14 important, I could have those provided to you.

15 MR. TRAVERS: Well, I am going to ask
16 Mr. Ruf and Mr. Malik if they would be willing to provide
17 those journal articles that you've reviewed before your
18 deposition today.

19 MR. RUF: Sure.

20 MR. MALIK: No problem.

21 Q Did you review any texts?

22 A There are not a lot of texts written on
23 that subject. Mr. Malik was able to find an obscure text
24 from India, I believe, that he had a copy sent to me. It
25 wasn't really very helpful, didn't really add anything

1 above what I had learned from the journal articles.

2 Q Is that because of the language it was
3 written in or the information?

4 A No, it was in very good English, but it
5 just didn't add anything. I mean, it was description, and
6 I had already seen enough description, so it came sort of
7 late in the course of events.

8 Q The journal articles that you reviewed,
9 any idea how many there were?

10 A There are not many. It's -- I would say
11 a dozen, at most.

12 Q Were they all from a similar journal or
13 multiple journals?

14 A Multiple.

15 Q Can you identify the journals, if not the
16 articles?

17 A They're pretty obscure journals, too,
18 most of them. It would be an exercise of extreme amount of
19 memory.

20 Q I'll take that to mean you don't remember
21 the names of the journals?

22 A I don't remember, I'm sorry.

23 Q You teach residents?

24 A I do.

25 Q Are there standard texts or journals that

1 you use in the training of your pathology residents?

2 A Yes.

3 Q Can you identify those for me?

4 A Well, I think in autopsy pathology,
5 probably one of the best is Robbin's Pathologic Basis of
6 Disease.

7 Q Do you know what the most recent
8 publication is of Robbin's?

9 A Just came out this year, I believe,
10 which I think is the eighth, maybe.

11 Q There was an earlier edition back at the
12 time that Mr. Gonda's autopsy was being performed?

13 A Yes.

14 Q Do you find Robbin's to be a reliable
15 textbook?

16 A Yes.

17 Q That's a yes?

18 A Yes, I'm sorry.

19 Q And of the various texts available to a
20 pathology resident, would you find Robbin's to be the most
21 authoritative of them?

22 MR. MALIK: Objection.

23 A It's a good bread-and-butter pathology
24 textbook. There are esoteric diagnoses that are not
25 covered, including endomyocardial fibrosis. It's not

1 something that makes it into that type of textbook with a
2 lot of descriptive detail.

3 Q The information contained in the text,
4 though, if it's in there, it's reliable --

5 A Yes.

6 Q -- information?

7 A Yes.

8 Q Are there journals that also you would
9 find to be equally authoritative?

10 MR. MALIK: Objection.

11 A Yes. I mean, I think that there are
12 journals that I regard highly. New England Journal of
13 Medicine, I believe, is a good journal. American Journal of
14 Pathology. There are reliable journals, but you have to
15 search far and wide to find coverage of that particular
16 topic.

17 Q Those journals and Robbin's text
18 certainly do include information, though, concerning
19 autopsy pathology in cases of infective endocarditis?

20 A Oh, yes.

21 Q And you find the information contained in
22 those journals reliable and authoritative on that issue?

23 A Generally, yes.

24 Q In addition to -- have we talked about
25 all of the literature research that you have performed?

1 A I believe so, yes.

2 Q I believe from your report you were also
3 provided with clinical records for this patient?

4 A I was.

5 Q Have you studied all of those?

6 A Yes, and they are voluminous.

7 Q Would you identify for me what records
8 you have, please?

9 A Okay. I have a copy of the autopsy
10 report from the Cleveland Clinic. I have a copy of an
11 admission to St. Elizabeth Hospital of 4/23/75. I have a
12 University Hospitals of Cleveland record from 5/27/94. I
13 have a University Health Services record from -- there's no
14 date. Cover letter says December 6, 1995. That may just
15 have been the day that it was mailed out, I'm sorry. Let's
16 see. Well, no, this goes back to -- it goes as far back as
17 1986 through 1995, apparently.

18 Q I'm sorry to interrupt you. The 5/27/94
19 UH record, that's for an inpatient admission?

20 MR. FRASURE: It's University Health
21 Services, isn't it?

22 MR. RUF: It's University Health
23 Services.

24 Q The one before that, I thought you
25 identified University Hospitals.

1 A No, this is University Hospitals
2 admission.

3 Q And that is an admission?

4 A It appears to be, yes.

5 Q You have reviewed that admission?

6 A Uh-huh.

7 Q Do you know what the reason for the
8 patient's admission was? I don't believe that that's a
9 record that's been provided to me previously.

10 A It says cellulitis of face. Let's see.
11 Then some records from Dr. Adornato in Youngstown.

12 Q Okay.

13 A Some records from Pulmonary
14 Rehabilitation Associates; some records from Dr. Juan Ruiz.

15 Q That's my client.

16 A Okay. Some admissions from -- some
17 records from St. Elizabeth's, 8/15/95 admission; an
18 emergency room record apparently from St. Elizabeth's
19 Hospital on -- I'm sorry, I don't see the date on these
20 forms. A history and physical from St. Elizabeth's
21 Hospital from an 8/15/95 admission; progress notes from the
22 same admission, St. Elizabeth's Hospital; some
23 consultations from the same admission; a report of an
24 echocardiogram from the same admission; report of a
25 transesophageal echocardiogram from the same admission.

1 Q I'm sorry to interrupt, Doctor. You've
2 never seen tapes of any of the echocardiograms performed on
3 him, have you?

4 A Yes, I have.

5 Q Not the TEE. Any others?

6 A That's the only one I believe I've seen.

7 Q That's the only one I'm aware of that
8 exists. That's what I wanted to make sure.

9 A I have laboratory reports from the same
10 admission, apparently. Electrocardiogram from the same
11 admission. Some doctors orders.

12 Q These are all different tabs for
13 different parts of the same admission chart?

14 A Yes.

15 Q You don't have to identify each
16 individual section.

17 A Then we jump to an admission at Cleveland
18 Clinic Foundation, 8/17/95, which is also broken down into
19 several tabs, and which ends with an Autopsy Report and
20 Death Certificate.

21 Q I suppose it's a lawyer's nature to be
22 nosy, but in addition to the materials in the binder, there
23 seem to be also a lot of loose documents that you've
24 brought with you here as well.

25 A Yes.

1 Q Can I take a look at those for one
2 second?

3 A These are mostly experts' reports, copies
4 of my own reports.

5 MR. FRASURE: Can I see the Death
6 Certificate, Doctor, while he's looking through there?

7 THE WITNESS: (Complying).

8 MR. FRASURE: Thank you.

9 Q As I understand the sequence of events,
10 Doctor, you were provided with these medical records and a
11 bunch of slides. You reviewed them, you authored a report,
12 and in that original report back in October of '97, you
13 suggested it might be helpful if you could get some new
14 slides. Those were provided to you, and then you dictated
15 a supplementary report?

16 A That is correct.

17 MR. FRASURE: I think the first
18 report is March of '97.

19 Q That's the point I want to get to, the
20 report dated March of '97 I'm guessing is misdated. You
21 wrote the first report in October of '97, then issued
22 another report that is dated March of '97 in which you have
23 already seen the slides that you had asked for in the
24 report of October of '97. Do you follow me? I guess my
25 question is, do you know when you dictated -- do you know

1 when that March of '97 report was prepared?

2 A No. That does appear to be an error. I
3 usually rely on the word processor to automatically enter
4 the date, and apparently I had locked in the date in the
5 word processor, and so it did not update automatically when
6 I authored this. That is -- I do not know.

7 Q The report dated March 9 of 1997 was a
8 report that was done after the report that is dated October
9 of '97; do you agree with that?

10 A Yes, that follows. That is correct,
11 because it clearly has information that was additional to
12 the original report. And -- well, let me see. What was
13 the date that I sent this to -- wait a minute. Oh, it's
14 3/17/98. That's the issue. Yes, the date was -- it's
15 probably the year was in error.

16 Q It appears likely that the report dated
17 March 9 of '97 was, in fact, dictated in March of '98?

18 A That is correct. I believe that's true.

19 Q You have not prepared any additional
20 reports since that time?

21 A No.

22 Q Have you authored any earlier drafts of
23 either of these two reports?

24 A I don't believe so, no. That was -- I
25 believe you have two reports which just reflect an update

1 of the information based on the additional material.

2 Q Would you be able to summarize for me in
3 a nutshell any substantial change in opinion between the
4 two reports? I recognize that the narrative includes what
5 additional testing you reviewed and things, but is there a
6 substantial change in your opinion between those two
7 reports?

8 A No, not a substantial change.

9 Q Is there any change in the opinions that
10 you hold that you can identify?

11 A No.

12 Q One of the reasons I ask is that my
13 recollection -- and I don't have both of the reports right
14 here in front of me right now, but I believe that you
15 indicated in your first report that this was an infective
16 endocarditis, and your supplementary report specifically
17 identifies it as a bacterial endocarditis. Do you
18 recognize whether that's a correct distinction between
19 those reports? And I'm referring to --

20 A The bottom of the page?

21 Q Exactly.

22 MR. FRASURE: Where are we, Tom?

23 MR. TRAVERS: The final list of his
24 anatomic diagnoses. The first one from the October '97
25 report says acute endocarditis, probably infective in

1 etiology. The March of '98 report says acute bacterial
2 endocarditis.

3 MR. FRASURE: Probably polymicrobial?

4 MR. TRAVERS: Yes.

5 A I believe that is just a refinement of
6 the previous diagnosis based on the additional material,
7 not really a substantial change.

8 Q Well, when you dictated your original
9 report, my perception was that you thought that the
10 infective endocarditis could have had either a bacterial or
11 a fungal origin?

12 A That's true.

13 Q And at the time you dictated your second
14 report, then, you have now eliminated fungal endocarditis
15 from the opinions that you hold as to what this autopsy
16 showed?

17 A That is -- yes, that is a reasonable
18 assumption.

19 Q Why did you effect that change?

20 A Because I have positive cultures from the
21 autopsy which demonstrate numerous microorganisms, and my
22 special stains that I performed on the additional -- on
23 stained slides that were provided to me indicated the
24 presence of bacterial organisms.

25 Q But they also indicated the presence of

1 fungal organisms, did they not?

2 A On the culture report, there is a -- I
3 believe a *Saccharomyces cerevisiae* that was identified, but
4 I don't see *Saccharomyces* in the slides. Fungal organisms
5 tend to stand out like a sore thumb on special stains.
6 Bacterial organisms can be much more subtle.

7 Q Okay. I have reread that portion of your
8 March report and will acknowledge that perhaps I misread it
9 before. You're not saying that you identified fungal
10 pathogens on the staining that you did. You are commenting
11 that those were indicated on the original autopsy at the
12 Clinic?

13 A They come from the culture report from
14 the Clinic, yes, which was provided to me later. I didn't
15 have that at my first review.

16 Q In any event, you no longer believe that
17 there was a fungal etiology for what you believe to be the
18 patient's endocarditis?

19 A No, I don't think so.

20 Q Would it be accurate, Dr. Hoffman, that
21 the major thrust of the opinions that you hold in this case
22 is articulated in your written report of March 9 in what
23 we've deemed to be 1998?

24 A Yes.

25 Q One of the reasons I ask that is because

1 your report does not address whether the medical care
2 rendered to this patient by Dr. Cropp and by my client, Dr.
3 Ruiz, was acceptable or deviated from the standard of care.
4 My perception from your report is that it is not your
5 intention to render any opinions concerning the
6 reasonableness of the treatment which this patient received?

7 A I will not comment on any aspects of the
8 patient's care.

9 Q Do you have some understanding of the
10 nature of the claims that are being made against the
11 defendant physicians in this lawsuit?

12 A Very little, to be honest with you. I
13 don't.

14 Q Do you have an understanding that the
15 opinions that you have authored here in your report are a
16 prerequisite to the Gonda family proving that the defendant
17 physicians committed medical malpractice in this case?

18 MR. RUF: Objection.

19 A I assume that there is some process that
20 brought this case to Mr. Malik's attention. My role in
21 this process is to review the autopsy findings.

22 Q You do acknowledge that there's a
23 difference of opinion concerning the nature of the disease
24 process which Mr. Gonda suffered, even after he died when
25 the autopsy was performed? There's a difference between

1 you and the Cleveland Clinic conclusion; correct?

2 A Yes, a very great difference.

3 Q Can you tell me how frequently in your
4 profession substantial differences of that nature occur in
5 the interpretation of autopsy findings?

6 MR. MALIK: Objection.

7 A They certainly occur in cases that are
8 performed by individuals who do not have a great deal of
9 experience, who may not have resources to investigate the
10 findings that they're observing.

11 Q I don't want to interrupt you. Is your
12 answer completed?

13 A It's complete.

14 Q Would you agree that in circumstances
15 where you have pathologists who are well trained, with a
16 reasonable degree of expertise and reasonable resources
17 available to them, that it is a fairly unusual occurrence
18 that there would be such a dramatic difference of opinion,
19 as is evidenced in this case?

20 MR. MALIK: Objection.

21 A I would think that, given a great deal of
22 expertise and adequate resources, it would be difficult for
23 this degree of discrepancy to arise. Yes, I am surprised
24 that there is this degree of discrepancy, to be honest with
25 you.

1 Q Would you agree that it is reasonable to
2 conclude that if there's such a degree of discrepancy even
3 after the patient died, that it is also reasonable to
4 believe that a clear indication of his disease process
5 would be difficult to ascertain while he was alive?

6 MR. RUF: Objection.

7 MR. MALIK: Objection.

8 A I would not make that assumption.

9 Q Do you hold an opinion, Dr. Hoffman,
10 concerning whether or not the individuals involved in
11 authoring the official Autopsy Report from the Cleveland
12 Clinic acted in a manner that was a violation of the
13 standard of care for practicing pathologists?

14 A The practice of pathology in most
15 teaching hospitals is a training function, which is often
16 performed by relatively inexperienced individuals, with
17 supervision from more trained staff. And at some point
18 there has to be a transition where pathologists begin to
19 take responsibility for their own Autopsy Reports. This
20 report strikes me as one that was authored by a relatively
21 inexperienced pathologist. I don't know this individual,
22 however.

23 Q Do you even know who drafted that report?
24 There's three names on it. I think we're going to find out
25 that information, perhaps, tomorrow, but I don't claim to

1 know at this point whose work that is. I think there are
2 two staff physicians and a resident, all whose names appear
3 on the cover page of the Autopsy Report.

4 A There's a Joseph Schreenan, who I don't
5 know, and a Dr. Sharon Hook that I don't know.

6 Q And a resident as well?

7 A Yes, and a resident, Nancy Wagg
8 (phonetic spelling).

9 Q Well, if you would, at my request, assume
10 that no matter who drafted that report, that it, before
11 becoming final, was reviewed and approved by an experienced
12 and competent staff pathologist at the Cleveland Clinic,
13 would that individual who rendered final approval of that
14 report have violated the standard of care for practicing
15 pathologists?

16 MR. RUF: Objection.

17 MR. MALIK: Objection.

18 A No, I don't believe that it would be a
19 violation of standard of care. I'm not sure in autopsy
20 pathology that standard of care really has the same
21 meaning. One tries to interpret what one sees as best one
22 can, and these people may very honestly believe that they
23 see what they're seeing here.

24 Q Well, perhaps this isn't entirely
25 accurate from a legal perspective, but the way I'm asking

1 the question from standard of care is whether or not the
2 person with ultimate approval upon review of this autopsy
3 who put the final stamp of approval on that report, would
4 that person be acting in a reasonable fashion, or are the
5 differences between your conclusions so unreasonable as to
6 constitute a violation of the standard? Basically I'm
7 using the test of reasonableness.

8 MR. MALIK: Objection.

9 MR. RUF: Objection.

10 Q Let me withdraw that question and ask a
11 different one, Dr. Hoffman. Here's all I'm trying to find
12 out with this line of questioning, is are we looking at two
13 pathologists who review the same materials and have a
14 difference of opinion, or are you saying that yours is the
15 reasonable interpretation of this study and theirs is an
16 unreasonable interpretation?

17 MR. RUF: Objection.

18 A I believe that my interpretation is the
19 reasonable interpretation of this study, and I believe
20 that --

21 Q I'm sure I knew that before coming today.
22 I guess my question is focused on the Cleveland Clinic
23 report. Is that an unreasonable conclusion that they
24 reached, or is it just a difference of opinion from what
25 you believe to be the correct conclusion?

1 A I believe it is an --

2 MR. RUF: Objection.

3 A It is an unreasonable opinion.

4 Q Let me ask the same question concerning
5 the Death Certificate. Do you disagree with the
6 conclusions of the Death Certificate on cause of death?

7 A The causes of death listed on the Death
8 Certificate are pulmonary hemorrhage, which is true. At
9 least it is present. The underlying intermediate cause is
10 listed as tumor emboli, which doesn't even agree with the
11 Autopsy Report as was originally written. And the
12 underlying cause of death that initiated the train of
13 events is listed as tumor of myocardium, parentheses, right
14 ventricle, which, again, really does not agree with the
15 findings even in the Autopsy Report.

16 I would add that Death Certificates are often written
17 without the benefit of autopsy results. In fact, the box
18 31-A, was an autopsy performed, is not checked, and box
19 31-B, were autopsy findings available prior to completion
20 of cause of death, is also not checked, so there's no
21 reason to assume that the physician who filled out the
22 Death Certificate had any clue of the autopsy results.

23 Q Well, do you disagree or do you agree
24 with the primary and secondary causes of death identified
25 on the patient's Death Certificate?

1 MR. MALIK: Objection.

2 A I disagree.

3 Q How would you have filled out that
4 section of the Death Certificate identifying the cause of
5 death?

6 MR. MALIK: Continuing objection.

7 A I believe that the immediate cause of
8 death was thromboembolism, probably infective, involving
9 the elastic pulmonary arteries. Intermediate cause of
10 death, acute bacterial endocarditis, probably polymicrobial
11 in etiology, involving endocardial scar in the right
12 ventricular outflow tract. And the underlying proximate
13 cause of death would be polymicrobial infection, site
14 unknown.

15 Q Okay. Dr. Hoffman, do you know how you
16 were selected to serve in the capacity of reviewing these
17 autopsy findings?

18 A I really do not. Mr. Malik called me and
19 described to me a fantastic -- that's the best word for
20 it -- clinical scenario that just didn't make sense to me
21 and asked if I would review the autopsy slides and attempt
22 to come to some sort of an opinion of my own about what I
23 was looking at. But I don't know how he found my name.

24 Q You've never had any previous dealings
25 with him?

1 A No.

2 Q Or Mr. Ruf?

No.

4 Q Have your services been previously
5 retained to serve as a consultant in medical-legal
6 disputes?

7 A Yes, they have.

8 Q On how many occasions?

9 A At varying levels, maybe ten or twelve
10 cases in the past.

11 Q Would they all be in the Cleveland area?

12 A Yes.

13 Q Have any of them dealt with issues
14 concerning causes of death?

15 A Yes.

16 Q All of them?

17 A All of them involve autopsy findings,
18 yes, and expert opinion related to autopsy findings.

19 Q Can you tell me how many of those,
20 approximately, involved cardiac causation?

21 A I'd say two or three of those.

22 Q And was there a dispute in those cases
23 concerning what actual type of cardiac causation occurred?

24 A In the other ones, no.

25 Q What would be the reason for your

1 participation, then, as an expert?

2 A I believe in attempting to put a time
3 frame around a particular set of events, particularly
4 germane to coronary artery disease, acute myocardial
5 infarction.

6 Q Have any of the cases that you've been
7 retained in previously dealt with -- I'm going to take a
8 guess, not with endomyocardial fibrosis probably; right?

9 A No, this case is unique in that regard.

10 Q How about infective endocarditis?

11 A I don't believe infective endocarditis,
12 although I do believe that one of the cases did involve
13 nonbacterial thrombotic endocarditis.

14 Q Do you have a recollection of any
15 identifying information concerning that case, for example,
16 what lawyers were involved, what the patient's name was,
17 anything of that nature?

18 A I believe it was a guy from Nuremberg,
19 Plevin. It might be Tom Mester was the attorney that was
20 involved. I cannot remember the name of the patient.

21 Q Do you recall whether you rendered a
22 deposition in that case?

23 A You know, I don't specifically remember
24 whether or not that one made it to deposition. I know that
25 one's also settled at this point, but I don't believe I can

1 remember if we did a deposition or not.

2 Q Have these all been medical malpractice
3 cases that you've been involved in, or is there a wider
4 variety of cases where your expertise has been sought?

5 A Medical malpractice I believe they all
6 are, yes.

7 Q Can you tell me how many of those cases
8 you have rendered reports or testimony on behalf of the
9 defendant physician or hospital?

10 A It's a good mix. I'd say it's almost
11 evenly divided.

12 Q Do you take any actions to make it known
13 that you might hold yourself available to act as a
14 consultant in medical-legal matters?

15 A There is no reason to do that. People
16 find you. No, I do not advertise in any way.

17 Q Have you ever been sued for medical
18 malpractice?

19 A I have not.

20 Q Can you explain to me, Dr. Hoffman, your
21 reasoning in agreeing to act as an expert consultant in
22 this particular case? Why is it that you're doing this?
23 What's your motivation?

24 A I believe that this is a very good way to
25 get exposure to cases that are otherwise considered to be

difficult. I do bill for my services, so there's a financial incentive. I believe in this case the original Autopsy Report was not accurate and that the accurate Autopsy Report, even had this case not been pursued into litigation, provided some degree of comfort to the relatives of the deceased in knowing, perhaps, a little bit better what caused the death of their son. So there are many reasons.

Q I'm from Youngstown and don't claim to know this, but my sense is that there's sort of an inter-city rivalry between UH and the Clinic that is ongoing here. Is that accurate?

MR. MALIK: Objection.

A I have a great deal of respect for the Pathology Department at the Clinic. I believe our institutions do compete for patient care, and it's, I think, fairly well known that medical care is a competitive field. I'm not motivated by that in any sense.

Q Depending on the outcome of this case, would it be your inclination to communicate a misdiagnosis by the Pathology Department of the Cleveland Clinic among your peers?

A That would not be my immediate goal, no.

Q Well, I don't think that that was the question I asked, if that was your immediate goal. Is it

1 likely that you would do that?

2 A It is possible, yes. I mean, should such
3 a case ever arise again, I think that it would have to be
4 understood that misdiagnoses do occur.

5 Q Would you take some delight in being able
6 to do that?

7 A No, no particular delight.

8 Q You mentioned your monetary compensation.
9 How is it that you're being paid for your services in this
10 case?

11 A I am providing bills to Mr. Malik, and he
12 is providing me or has provided me with one payment up to
13 this point.

14 Q Certainly you have no -- the amount that
15 you bill or are paid is in no way dependent upon the
16 outcome of the lawsuit?

17 A No, absolutely not.

18 Q Is it strictly an hourly fee arrangem nt?

19 A That is correct.

20 Q And what is your hourly fee that you are
21 charging?

22 A \$250 per hour for testimony, not sworn.

23 And for this procedure here we're going for \$500 an hour.

24 Q You don't like taking oaths? Or maybe
25 I'm not clear on why there's such a huge distinction. Does

1 it depend on who's paying you?

2 A No, it really does not.

3 Q Why is it twice as expensive to give
4 sworn testimony as unsworn testimony? I don't understand.

5 A I believe that it is customary among
6 expert witnesses to make that distinction, and I believe
7 that testimony under oath is a much more formal and much
8 more stressful event.

9 Q Can you tell me how many hours you have
10 spent so far before your deposition today in reviewing this
11 matter and authoring your various reports?

12 A I believe that my account with Mr. Malik
13 thus far has included about \$1,800 worth of payments. So
14 if you do the division there, that is all it --

15 Q I saw that note, though, but I thought
16 that was prior to the time that you got the new slides and
17 authored the addendum report.

18 A Right. I have not billed him since, and
19 I would imagine that the amount of time since then may have
20 been about \$1,000, maybe, beyond that. I'm not absolutely
21 certain.

22 Q Do you keep any independent records of
23 the amount of time that you spend prior to preparing your
24 formal invoice?

25 A Yes, I do.

- 1 Q Where do you have those records?
- 2 A I keep those at home.
- 3 Q Doctor, have you ever performed an
- 4 autopsy on a patient with endocardial fibrosis?
- 5 A I have not.
- 6 Q Had you ever heard of that disease
- 7 process prior to your involvement in this case?
- 8 A Yes, I have.
- 9 Q And what was your knowledge of that
- 10 disease before the Gonda matter?
- 11 A That it is a rare entity, essentially
- 12 confined to equatorial Africa and equatorial South America;
- 13 that there is some question about the nature of the
- 14 process, you know, the cause being relatively unknown,
- 15 completely unknown.
- 16 Q You've never been involved in a case
- 17 where that condition has been diagnosed?
- 18 A Absolutely not.
- 19 Q And you would claim no independent
- 20 information concerning the etiology of that disease
- 21 process?
- 22 A No, I have no information about that.
- 23 Q Do you know whether it's infectious in
- 24 nature?
- 25 A I don't believe that anybody does,

1 Q What types of -- I'm going to call it EMF
2 for endomyocardial fibrosis, if that's okay with you.

3 A That's fine.

4 Q What types of EMF are you familiar with?
5 Are you aware of different classifications?

6 A I believe that it can be classified on
7 the basis of the location of involvement in the heart.
8 There's left-sided and right-sided endomyocardial fibrosis.
9 There is also a spectrum of disease that ranges from that
10 which is described in Africa to an entity which is
11 sometimes seen in this country known as Loeffler's
12 endocarditis.

13 Q Do you agree that Loeffler's is a
14 sub-category of EMF?

15 A I don't believe that's necessarily true,
16 no.

17 Q Can you identify any distinctions in the
18 way that those diseases manifest themselves at end stage?

19 A Not at end stage, necessarily. But the
20 classic description of Loeffler's endocarditis involves a
21 prominent blood eosinophils.

22 Q I indicated I'm going to use EMF. Can I
23 use EO's too?

24 A Sure.

25 Q What is your understanding of the

1 involvement of the EO's in the development of Loeffler's
2 endocarditis?

3 A I don't believe that the causal mechanism
4 is clear. The presentation of high numbers of eosinophils
5 in the blood is somehow believed to cause a scarring
6 reaction in the lining of the heart, similar to that which
7 is also seen in a condition known as carcinoid syndrome.
8 Somehow substances released from neuroendocrine tumors or
9 from eosinophils in the blood cause this scarring reaction
10 in the lining of the heart.

11 Q Have you ever been involved in doing an
12 autopsy of a patient with Loeffler's endocarditis?

13 A I believe I have seen them, but I have
14 not performed them.

15 Q And you've seen the resulting scarring
16 from that condition?

17 A Yes

18 Q Can you identify it for me, how that
19 scarring would be different in substance than the scarring
20 presented by Mr. Gonda?

21 A The scarring in that condition is what we
22 pathologists call very bland. It's collagen that is laid
23 down in the lining of the heart with little or no
24 inflammatory infiltrate. In contrast is Mr. Gonda's heart,
25 the lining of which is a very hot, acute inflammatory

1 reaction.

2 Q Can one tell on post whether scarring
3 was, in fact, the result of eosinophils or not?

4 A Only by association with the other
5 findings at the time of the autopsy. But scar tissue is a
6 fairly stereotypical end stage result of most damage to the
7 heart. You can have scarring in the heart caused by a
8 myocardial infarct, by an infection, by a degenerative
9 process. And once you have a scar, it's a scar. It's very
10 difficult to go further unless you have another clue to
11 help you.

12 Q What findings would you be looking for in
13 other organs if the scarring of the heart was the direct
14 result of eosinophils?

15 A First of all, I would look for
16 eosinophils either in laboratory reports prior to the time
17 of death or in deposits in tissues. Eosinophilia may result
18 from a neoplastic or preneoplastic condition, in which case
19 one would expect to see abnormalities in the bone marrow
20 which would lead one to suspect that there may be increased
21 production of these cells and their release into the blood.

22 Q Are you aware of a disease entity called
22 non-African endocardial fibrosis, endomyocardial fibrosis?

24 A I believe the term has been used to
25 describe some cases that resemble the African form and have

1 not occurred in individuals in Africa, yes.

2 Q Are you aware of whether there are cases
3 of that nature that have occurred in the United States?

4 A I believe I received a copy of a report
5 from the Cleveland Clinic about that very topic.

6 Q So that you're aware that there have been
7 at least two diagnosed conditions of non-African EMF here
8 in Cleveland; correct?

9 A I've seen that report.

10 MR. RUF: Objection.

11 Q Do you have any reason to doubt the
12 accuracy of that report?

13 A No.

14 Q Do you know Dr. Moody?

15 A No, I do not.

16 Q Well, is part of the reason -- well, let
17 me ask this first. Your opinion is that this patient did
18 not have any type of endomyocardial fibrosis; is that
19 accurate?

20 A That is accurate.

21 Q Is that conclusion based at all on the
22 rarity of the disease?

23 A Yes, it is. Common things are common.
24 We have to work with a certain spectrum of diseases that we
25 see in our population and only with great trepidation go

1 outside of that.

2 Q Well, that is generally true of
3 clinicians, wouldn't you agree?

4 MR. RUF: Objection.

5 Q Let me ask the question differently.
6 Don't you think that, in light of the rarity of that
7 disease, that the individuals at the Cleveland Clinic would
8 give careful consideration before authoring an Autopsy
9 Report saying that that was the cause of this patient's
10 death?

11 MR. RUF: Objection.

12 MR. MALIK: Objection.

13 A I would think so.

14 Q I mean, if you're going to go out on a
15 limb and identify an extremely rare breed of disease, it's
16 not something that a reasonable pathologist does without
17 careful consideration?

18 MR. MALIK: Objection.

19 A I believe a pathologist has to consider
20 very carefully the reasonableness of the diagnoses that he
21 reaches. And one of the criteria that determines whether a
22 disease is reasonable is whether or not it is a common
23 disease in our population.

24 Q Based upon your review of the journal
25 information, are you aware of the characteristic findings

1 of EMF autopsies?

2 A I believe so, yes.

3 Q Would you agree that a primary component
4 of those is a fibrotic lesion of the heart?

5 A Yes, that is true.

6 Q Mr. Gonda had such a fibrotic lesion, did
7 he not?

8 A He had a fibrotic lesion, but not one
9 which was typical of the descriptions of endomyocardial
10 fibrosis, either African or the ones that have been
11 reported in the United States.

12 Q Doctor, I'd like to go back to the
13 beginning of the deposition today when I was asking about
14 whether you were just an expert or an advocate. And the
15 reason I mention that again is because I'm not looking,
16 hopefully, today for you to advocate your position by
17 supplementing information to the questions that I'm asking,
18 and I would request that you not do that.

19 MR. RUF: I'm going to object. He
20 can answer the questions as he sees fit. And he's here to
21 answer the questions. He doesn't have to answer them
22 exactly as you want him to answer them.

23 Q Here's my question, Doctor. Did Mr.
24 Gonda, on autopsy, present with a fibrotic lesion of his
25 heart?

1 A Yes.

2 Q Are you aware of the general clinical
3 findings on autopsy as to where fibrotic lesions are
4 located in EMF patients?

5 A Yes.

6 Q What is your understanding of that issue?

7 A That they tend to involve the apices of
8 the ventricular cavities and extend from the apices toward
9 the base, progressively involving the AV valve mechanisms.
10 Left tends to be more common than right.

11 Q Sometimes both?

12 A Sometimes both.

13 Q But Mr. Gonda's lesion was in his right
14 ventricle; correct?

15 A Correct.

16 Q And that is one of the areas identified
17 historically as a common site of EMF fibrotic lesions, the
18 right ventricle?

19 A It is the less common of the ventricles,
20 yes.

21 Q I'm not sure how I want to address this
22 next issue with you, Dr. Hoffman, but I'm not asking what
23 is more suggestive or less suggestive of EMF in these
24 autopsy findings. But what I would like you to do is, from
25 either your review of the original Cleveland record, the

1 Autopsy Report, or from your review of the microscopic
2 findings, including the slides that you had prepared for
3 your review, if you can identify for me findings that you
4 believe to be absolutely inconsistent with the existence of
5 EMF?

6 A Okay. I believe that the presence of
7 lung abscesses in the setting of septic thromboemboli and a
8 suppurating lesion of the endocardial surface are
9 inconsistent with the diagnosis of endomyocardial fibrosis.

10 MR. BLOMSTROM: Could I get the
11 second one again? I didn't catch that.

12 A Suppurating lesion of the endocardial
13 surface.

14 Q You agree that lesions of the endocardial
15 surface are common in EMF patients?

16 A They are the very nature of EMF.

17 Q So the reason that this particular
18 finding you identify as inconsistent is because of the
19 adjective you used that I'm not going to try to pronounce?

20 A Yes. Full of pus is what that adjective
21 means.

22 Q What is your basis of concluding that the
23 lesion was suppurating?

24 A Suppuration is identified by the presence
25 of abundant neutrophil leukocytes in the lesion.

1 Q And you are able to identify abundant
2 leukocytes in this lesion?

3 A Abundant polymorphonuclear leukocytes,
4 yes.

5 Q And how is it that you reached the
6 conclusion that there were abundant leukocytes?

7 A To use a lay expression, they were wall
8 to wall, whole fields filled with them in the microscope.

9 Q Is there anything else about the findings
10 on autopsy or your review of the slides contradictory to
11 the existence of endomyocardial fibrosis, other than the
12 lung abscesses and the suppurating nature of the lesion?

13 A Examining the materials that I had to
14 determine the distribution of the lesions in the heart, and
15 here I'm speaking most specifically of the gross
16 photographs of the heart, which I was provided, it appears
17 that the lesion spares the apex of the right ventricle.

18 Q There are case studies of EMF patients
19 where the lesion was not in the apex of the ventricle;
20 isn't that true?

21 A I don't believe I can adequately answer
22 that question.

23 Q Is it your testimony that the lesion must
24 be in the apex of the ventricle in order for it to be an
25 EMF lesion?

1 A No.

2 Q I want to ask you some questions about
3 infective endocarditis, and I guess based upon your
4 supplementary report, we can limit this now to bacterial
5 endocarditis; okay?

6 A That's fine.

7 Q Just as an intellectual pursuit, if you
8 would, if I were to present this case, the David Gonda case
9 to you with the diagnosis of bacterial endocarditis and ask
10 you to make a list of all of the contraindications that
11 that would be a correct diagnosis, can you help me with
12 such a list?

13 A Do you mean absolute contraindications or
14 relative contraindications?

15 Q I'm going to ask you about both, and I'd
16 be happy to allow you to answer them together or
17 separately, at your preference.

18 A Okay.

19 Q I'm going to assume that you don't
20 believe there are any absolute contraindications or that
21 wouldn't be your diagnosis; right?

22 A Right. This case is relatively unusual,
23 in that the inflammatory reaction does not appear to
24 specifically involve the valves. That places it in a
25 category of endocarditis called mural endocarditis, which

1 tends to occur in two different settings. One is overlying
2 diseased myocardium, and the other would be in the setting
3 of an infection being spread from elsewhere in a solid
4 form, as perhaps by embolic disease. So this case differs
5 from most examples of infective endocarditis that you will
6 see in this one important aspect.

7 Q I suppose I shouldn't try to put words in
8 your mouth, but it's my impression from my literature
9 review that valvular involvement is a hallmark of infective
10 endocarditis; is that not accurate?

11 MR. RUF: Objection.

12 A That is not accurate.

13 Q Can you estimate for me what percentages
14 of patients who demonstrate infective endocarditis have
15 valvular involvement?

16 A The overwhelming preponderance, 98
17 percent plus, probably, have valvular involvement, and then
18 there are a rare number of cases that have mural
19 endocarditis.

20 Q And just so that we're clear on this
21 point, there is absolutely no demonstration in Mr. Gonda's
22 case that there's involvement of any of his cardiac valves;
23 correct?

24 A The materials that I have to answer that
25 question are limited to the descriptions of the

1 pathologists who examined the case. I have no sections of
2 the valves, and I have no photographs of the valves, so I
3 take it at their observation that they did not see
4 vegetations, which would be the classic finding in
5 infective endocarditis on the valves.

6 Q And, in fact, they note that in their
7 report?

8 A Yes.

9 Q Would you help me understand the term
10 vegetation?

11 A Sure.

12 Q What does that mean from a medical
13 perspective?

14 A It's descriptive. It essentially means a
15 growth, a friable growth that accumulates on the surface of
16 a cardiac valve or on the lining of the heart. It may or
17 may not be infected. It's composed of very soft plasma
18 protein, fibrin, predominantly.

19 Q Are there any findings in this case that
20 you're aware of that you would consider to be suggestive of
21 the existence of vegetations?

22 A Yes. I think that the masses that were
23 observed on the echocardiogram that the autopsy
24 pathologists identified sticking out into the lumen of the
25 right ventricular output tract could be considered to be

1 vegetations.

2 Q Would it be the same type of vegetations
3 that you would normally find attached to the heart valves
4 in patients with infective endocarditis?

5 A No.

6 Q Would it be a correct statement that
7 there is no suggestion that the type of vegetations
8 normally found in patients with endocarditis are evidenced
9 in Mr. Gonda's case?

10 A That's, I think, a reasonable statement.

11 Q Would you agree that the percentage of
12 patients who have endocarditis and experience vegetations
13 also probably comprise more than 90 percent of endocarditis
14 patients?

15 A I'm not sure I'm following that question.

16 Q Well, you told me before that more than
17 98 percent of patients with endocarditis generally have
18 some valve involvement?

19 A Right.

20 Q Would you agree that more than 98 percent
21 of the patients with endocarditis present with signs of
22 vegetations?

23 MR. FRASURE: Anywhere or on the
24 valve?

25 Q Anywhere. Anywhere in the heart.

1 A That's not necessarily true. I mean, are
2 you talking present, you mean seek medical attention?

3 Q No, even upon autopsy if never
4 previously -- have, I guess is what I mean. More than 98
5 percent of patients with infective endocarditis develop
6 cardiac vegetations?

7 A Yes.

8 Q And that is something that, if it is
9 evident upon autopsy, you would certainly expect to be
10 identified in the Autopsy Report?

11 A Yes.

12 Q And, again, there's none in Mr. Gonda's
13 case?

14 A That's correct.

15 Q Have you ever personally done an autopsy
16 on a patient with endocarditis that did not have valvular
17 involvement?

18 A Yes.

19 Q That was a mural?

20 A Yes.

21 Q In regard to the mural type of
22 endocarditis, you indicated that there's two sub-categories
23 there, one where it is overlying a diseased myocardium. Do
24 we have any reason to believe that that was present in Mr.
25 Gonda's case?

1 A Not specifically, no.

2 Q Well, do you have an opinion as to which
3 of the two types of mural endocarditis he experienced?

4 A I believe that he may be having -- it's
5 more likely that he's having embolism of infected material
6 to the heart and lungs.

7 Q This is, perhaps, just an aside, but of
8 some significance to my client, Doctor. When a patient
9 with endocarditis develops vegetations on his heart valves,
10 is that something that normally an examining clinician can
11 pick up by auscultation?

12 A I believe that changing heart murmurs are
13 observed in patients with endocarditis, yes, with valve
14 involvement.

15 Q So if you listen to the patient's heart
16 and hear no signs of any changing heart murmurs, you would
17 agree that if that patient had endocarditis, he would be in
18 the two percent of those patients or less who have no
19 valvular involvement?

20 A Well, first of all, I do not listen to
21 hearts. But without involvement of the valves, the
22 mechanism for the unusual sounds would seem to be absent.

23 Q Because what clinicians are looking for
24 when they listen to the heart valves are signs of
25 developing vegetation?

1 MR. RUF: Objection.

2 MR. MALIK: Objection.

3 Q Never mind. Let me withdraw that.
4 You've indicated that you don't listen to hearts, so I'll
5 save that for one of the other numerous experts we have in
6 the case. Okay. We've talked about vegetations; we've
7 talked about valve involvement. Would you agree that, as a
8 general rule, patients with endocarditis do not have
9 findings of polymicrobial pathogens?

10 A I'm sorry?

11 Q Let me ask it like the lawyer I am,
12 rather than the materials I read. It's my perception that
13 in patients with endocarditis, that usually upon autopsy,
14 you can see a single pathogen, as opposed to a multiplicity
15 of pathogens; is that accurate?

16 A That is often the case, yes.

17 Q And that's how generally you can
18 conclude, because you see that one type of microbe, that
19 that was the bacteria causing the disease?

20 A Yes.

21 Q In this case, you have no opinion
22 concerning which specific bacterium was the cause of what
23 you believe to be the patient's endocarditis?

24 A I believe there are some organisms in the
25 culture results that raise my concerns a little bit more

1 than others.

2 Q But there are multiple pathogens in those
3 results, are there not?

4 A Yes. Multiple pathogens is actually a
5 type of infection. If an infection spreads from the
6 gastrointestinal tract, most often or very often it can be
7 polymicrobial, often involving anaerobic organisms, as was
8 seen here.

9 Q Well, do you hold an opinion as to which
10 of those pathogens identified in your report were the cause
11 of what you believe to be endocarditis?

12 A I believe in this case the organism that
13 was identified as belonging to the Bacteroides fragilis
14 group is of particular concern.

15 Q Is that the enterococcus?

16 A No, the Bacteroides.

17 Q How many different types of bacteria did
18 you identify in your stain slides?

19 A The stain is not a very reliable way to
20 speciate bacteria. I saw both gram positive and gram
21 negative organisms on the slide that I examined.

22 Q But at least three different species of
23 gram positive, did you not?

24 A No, you're looking at the results in
25 culture, and you cannot --

1 Q You're right. You're right. I
2 apologize. The culture is a reliable source of identifying
3 the existence of pathogens, though, is it not?

4 A It certainly provides a more definitive
5 identification of an organism than one could ever achieve
6 using staining alone.

7 Q Well, let's set aside that report for a
8 moment and concentrate just on your slides. How many
9 species of gram positive bacilli did you identify?

10 A I cannot identify their species based on
11 the stain. I can just say that it's a gram positive rod.

12 Q Okay. You say both gram positive and
13 gram negative?

14 A Rods, correct.

15 Q But there's nothing on -- I'm not trying
16 to be tricky here. I understand that you cannot identify
17 the species from the slides. But for that reason, then,
18 there's nothing on the slides that would dispute the
19 existence of at least three different species of gram
20 positive bacilli identified on the Path Report; would that
21 be accurate?

22 A I think that's accurate, yes.

23 Q And wouldn't you agree that these are all
24 additional indications that if this patient had
25 endocarditis, he was in an extremely minute type of that

1 disease process?

2 A These are not usual pathogens seen in
3 endocarditis, if that's what you're driving at.

4 Q What are the most frequent pathogens
5 causing bacterial endocarditis?

6 A Staph, Strep, in fact, organisms usually
7 not considered to be pathogens. The Strep viridans group
8 can get a foothold on a heart valve and create an infective
9 lesion. Gram negatives, much more rarely. I think that's
10 the -- probably described 95 percent of them right there.

11 Q Neither the pathology report nor your
12 slide review identifies either Staph or Strep pathogens;
13 correct?

14 A That's correct.

15 Q If I could bring you back just a little
16 bit, Dr. Hoffman, in my own mind, at least, I'm still going
17 on the issue of reasons that put into question a diagnosis
18 of endocarditis. And would you agree that the lack of
19 Staph and Strep bacterium would decrease the credence of
20 endocarditis as the correct diagnosis?

21 A No.

22 Q In a patient with infective endocarditis
23 on autopsy, would you expect to be able to identify certain
24 expected findings in other organs?

25 MR. FRASURE: Can you repeat that,

1 read that back, please?

2 Q I don't think it was well phrased. Let
3 me just try again. In a patient with infective
4 endocarditis, upon autopsy, are there certain expected
5 findings in organs other than the heart?

6 A Yes.

7 Q Can you identify what some of those are?

8 A Embolism from the involved chamber to the
9 next vascular bed. So in right-sided endocarditis, lung
10 abscess is found very commonly, as seen in this case. In
11 left-sided endocarditis, essentially any vascular bed in
12 the body, brain involved, kidney involved, any tissue can
13 receive a septic embolus in infective endocarditis on the
14 left side.

15 Q This patient had no evidence of infarct
16 to any organ, did he?

17 A I believe the Autopsy Report describes
18 lung infarct.

19 Q You're right. I apologize. There are no
20 other organs, other than the lung, where infarct is
21 identified in Mr. Gonda's autopsy; correct?

22 A I believe that's correct.

23 Q And none of the slides that you've
24 reviewed prompt you to disagree with the conclusion on lack
25 of infarct?

1 A I don't believe there are infarcts
2 outside of the lung, based on what I have seen.

3 Q Did you review that portion of the
4 Autopsy Report concerning what he calls or she calls the
5 external examination?

6 A I believe I did at one point, yes.

7 Q Let me ask first, isn't it generally true
8 that patients with infective endocarditis will present with
9 signs of that disease that are observable by an external
10 examination?

11 A Not necessarily, and specifically not
12 necessarily in a case of right-sided endocarditis.

13 Q Well, I was hopeful that I didn't pose my
14 question by way of necessarily, but isn't it generally true
15 that there is evidence of the existence of a patient's
16 endocarditis upon external examination?

17 A Only in left-sided endocarditis.

18 Q We've been at this a while, Doctor. If
19 I've asked you this already, I apologize. I don't think I
20 did. Can you estimate for me the percentages of patients
21 with endocarditis of the left side, as opposed to the right
22 side?

23 A Cases of right-sided endocarditis that
24 I've seen in the autopsies that I've performed have been
25 largely confined to individuals that had infected central

1 lines. And the tremendous majority of other cases involve
2 the left side, the mitral and aortic valves. I have not
3 seen a lot of cases of IV drug abusers, but infective
4 endocarditis on the right side of the heart certainly
5 raises the possibility of intravenous drug abuse as well.

6 Q I don't say this critically, because I
7 think you're trying to answer my question, but can you
8 translate that answer into percentages?

9 MR. FRASURE: Of right-sided versus
10 left-sided?

11 MR. TRAVERS: Correct.

12 A Right-sided, oh, maybe five percent.

13 Q Or less?

14 A Around in there. I'd say five, ten
15 percent, something like that, and the majority are on the
16 left side. But, again, the clinical setting -- I mean, if
17 you have a hospitalized patient who has had lots of
18 problems with central lines, I mean, you expect to see a
19 certain --

20 Q Well, when you read standard texts
21 concerning signs and symptoms of endocarditis, are you
22 aware whether they generally make a distinction between
23 right- and left-sided disease?

24 A I believe it's an important distinction,
25 yes. I think they do.

1 Q Well, looking at the disease process of
2 endocarditis as a whole, and not distinguishing between
3 right and left, can you tell me or do you know the
4 frequency of presentation of symptomatology by external
5 examination of those patients?

6 MR. MALIK: Objection.

7 A I believe I've already commented on that.
8 The presentation of external signs in endocarditis is
9 largely related to the embolization of material into the
10 arterial circulation in left-sided disease. In the case of
11 having endocarditis on the right side of the heart, those
12 are effectively filtered out by the capillaries of the
13 lung, and they just never make it to the peripheral
14 circulation. So does that answer the question? I'm trying
15 to be helpful.

16 Q Well, I believe that I have a grip on the
17 mechanism why you believe that that's an important
18 distinction, and I don't dispute that it is. But my
19 question is not -- I think I prefaced by saying looking at
20 the disease process of endocarditis as a whole, as opposed
21 to trying to distinguish right from left, isn't it true
22 that the majority of patients with that disease will have
23 symptoms observable by external examination?

24 MR. MALIK: Objection.

25 A To be honest with you, the majority of

1 patients that I have seen, even though they have disease on
2 the left side of the heart, I don't think they actually
3 have a lot of the external findings. They can be very
4 subtle and really be absent.

5 Q I am not a clinician. I don't claim to
6 know one if I tripped over one, but I continue to read
7 about petechiae and Osler's nodes and things of that
8 nature. Those are not prevalent in endocarditis patients,
9 in your opinion?

10 MR. RUF: Objection.

11 A Not in my opinion. I've seen some
12 spectacular cases of infective endocarditis, and to be
13 honest with you, the external examination is often
14 misleading.

15 Q Okay. You do agree that on post in Mr.
16 Gonda's case, there is no suggestion of any external
17 symptomatology suggestive that he suffered from
18 endocarditis?

19 A Yes, that's correct.

20 Q Again, attempting to identify potential
21 contraindications to your diagnosis, would you agree that
22 there are certain predisposition factors that patients with
23 endocarditis often have?

24 A Yes. Oh, absolutely.

25 Q Can you identify what those are?

1 A Virtually any intrinsic valvular disease,
2 for example, classic example, a patient with a history of
3 rheumatic fever who has had rheumatic carditis and has had
4 scarring of the -- one of the valves because of that
5 disease, for some reason those damaged valves are real
6 setups for infective endocarditis. That's why those people
7 take Penicillin when they have dental procedures and such.

8 Q Certainly patients with artificial
9 valves?

10 A And artificial valves. Any abnormality
11 of a valve seems to cause some sort of change. I'm not
12 sure what the nature of that change is, but the valve acts
13 like a magnet for bacteria after that point.

14 Q IV drug use can be a predisposing factor?

15 A We've already discussed that, yes.

16 Q Are you aware of any risk factors that
17 David Gonda had for endocarditis?

18 A He appears to have had some infections.
19 Having an infection in your body at some point can be a
20 predisposing factor, simply because organisms are on board.
21 And his history seems to indicate that he's had some ENT
22 problems, otitis media, sore throat. I mean, those sorts
23 of things would be risk factors.

24 Q I don't want to be argumentative, because
25 it's generally not my nature, Doctor, but that would

1 include anyone on the planet, then, as having that risk
2 factor; right?

3 A Well, in his particular case, my reading
4 of his chart indicates that he really was not well for
5 about 13 weeks before he died. And that does not include
6 most people on the planet.

7 Q Again, the sub-categories of potential
8 contraindications to endocarditis. Do patients who have
9 that disease generally present on autopsy with the type of
10 ventricular lesion that Mr. Gonda had?

11 A Absolutely not.

12 Q That exhausts my list of potential
13 contraindications. Are there other things that you're
14 aware of from your review of this case that a reviewing
15 clinician would pause and say, well, this would not appear
16 to support my conclusion of endocarditis?

17 A Well, Mr. Gonda was treated with
18 antibiotics. Again, I'm not an expert in infectious
19 disease, so I really cannot comment on the appropriateness
20 of the specific antibiotics that he did receive. But to
21 the extent that he did receive any microbial chemotherapy,
22 I suppose that would be a relative diminution of the
23 possibility. However, you get the wrong bug, and it's
24 completely an open issue.

25 Q Are you aware of the nature of the

antibiotic therapy that he received?

2 A I looked through that and did not write a
3 specific list. I do know that he received several.

4 Q It was a pretty broad-spectrum therapy
5 that he had?

6 A That is not mine to determine. I really
7 do not claim to be an expert in infectious diseases.
8 Antibiotics come out faster than I can keep track of them.

9 Q You used the term in your report acute
10 endocarditis.

11 A Yes.

12 Q That is opposed to subacute, I assume?

13 A Yes.

14 Q What is the distinguishing factor, in
15 your mind, between those two types of endocarditis?

16 A Acute really just implies a more
17 fulminate course. Subacute bacterial endocarditis is one
18 that can smolder along for a period of time and present
19 with a patient with waxing and waning fevers and
20 essentially a more chronic disease. It can be very
21 difficult to nail down. It's the one where clinicians will
22 have multiple, multiple blood cultures, and maybe on the
23 sixth of the series find their organism.

24 This acute, in my specific sense, is really an autopsy
25 finding. It's not a chronic lesion in that what I'm seeing

1 is populated with polymorphonuclear leukocytes and not
2 chronic inflammatory infiltrate lymphocytes and
3 macrophages, something that might be evidence of a much
4 older inflammatory process.

5 Q Can you distinguish in terms of days or
6 weeks between, in your mind, what you call acute and what
7 you call subacute?

8 A Not specifically. It actually turns out
9 more to be a description of the visual findings than
10 actually a reliable indication of how long the infection
11 has been there.

12 Q One thing you mentioned reminded me of a
13 note that I neglected to put down before. The negative
14 cultures would be another suggestion that this was not
15 endocarditis; correct?

16 A Yes. But, again, multiple negative
17 cultures sometimes go by in patients with infective
18 endocarditis, and you catch them in a fever spike when
19 they're seeding their organisms into the blood, and you
20 have a window of opportunity to make a diagnosis. Also, in
21 the background of antibiotic therapy, the ability to detect
22 microorganisms can be decreased.

23 Q Can you tell from your review of the
24 slides or of the photographs of the gross specimens how
25 long that lesion in the patient's right ventricle had been

1 there?

2 A Well, the fact that it is based on a scar
3 would indicate that it must have had a course of at least
4 several weeks just in order for some scar tissue to form.
5 However, the more luminal face of the lesion appears to be
6 very fresh, I mean, actively pouring out neutrophils into
7 the lesion.

a Q Explain to me, if you would, Dr. Hoffman,
9 the sequence of events in your mind that prompted the
10 development of the multiple layers of this lesion. I guess
11 I'm unclear. Are they all, in your judgment, the result of
12 the same disease process?

13 A For lack of another disease, I would have
14 to say yes. I believe, you know, he has one process. I
15 believe he has some form of an infection which manifested
16 itself as various complaints in his head and neck. He
17 subsequently had seeding of organisms to the heart and
18 lungs. I can't tell in what order those things began to
19 occur, but certainly they're both there by the end. I
20 presume that his respiratory symptoms, the intractable
21 cough, and hemoptysis that he evidenced in his final days
22 was probably evidence of the inflammatory involvement of
23 his pulmonary arteries. He had a very brisk vasculitis in
24 his lungs.

25 Q Would you agree that that vasculitis of

1 his lungs, that its onset was likely coincidental with the
2 beginning of his hemoptysis?

3 MR. MALIK: Objection.

4 A That would be reasonable, yes.

5 Q Do you know how long it was before his
6 presentation at St. E's that he first began coughing up
7 blood?

a A I don't remember specifically right now,
9 no. I believe that was toward the end of his course.

10 Q Recognizing that his acute
11 hospitalization at St. E's, transfer to Cleveland Clinic,
12 and death occurred in the middle of August, is there any
13 way, from your review of these autopsy findings, to
14 establish what the condition of his cardiac chamber and his
15 pulmonary status was back in June of that same year?

16 A No. That really, I don't think, can be
17 accurately addressed from the autopsy findings that I have.

18 Q In the outline of my notes, Doctor, the
19 last thing that I have to question you about are specific
20 issues from your dictation and your report. But if you
21 don't mind, we've been at this a while. I would really
22 like to excuse myself, use the restroom. All these other
23 lawyers have the report, too, and I may abdicate for that
24 part of the examination and see if anybody wants to ask you
25 about some of these other report findings. Is that okay

1 with you?

2 A That's fine with me.

3 MR. RUF: You want to take a break,
4 Doctor, or do you want to continue?

5 THE WITNESS: Oh, I can continue.

6 MR. TRAVERS: I'd like to take a
7 break.

8 (Whereupon a brief recess was taken.)

9 CROSS EXAMINATION:

10 By Mr. Frasure

11 Q Doctor, Mark Frasure on behalf of Dr.
12 Cropp and his partner. You mentioned earlier that because
13 you are the autopsy pathologist in this department, that
14 you see more heart autopsies, you might say, than your
15 other colleagues?

16 A I think that's reasonable, yes.

17 Q Other than that, do you specialize in the
18 heart more than your other colleagues?

19 A I find it particularly fascinating. It's
20 an area of interest of mine. But specialization, how --
21 how would you define that?

22 Q I notice you are Board Certified in
23 anatomical pathology?

24 A Correct.

25 Q Are you Board Certified in clinical

1 pathology?

2 A I am not.

3 Q You are not?

4 A I am not.

5 Q Are some of your colleagues here Board

6 Certified in clinical pathology?

7 A Yes, I believe so.

8 Q Have you taken that exam?

9 A Never have.

10 Q So what I understand here is you believe

11 the patient had a mural endocarditis; correct --

12 A That's correct.

13 Q -- on the right side, and polymicrobial

14 in nature?

15 A That's correct.

16 Q And caused by bugs that are not normally

17 causing that type of endocarditis; is that correct?

18 A That's correct.

19 Q So we've got an unusual part -- well,

20 first of all, *you* said mural is unusual?

21 A Right.

22 Q Within mural, is right-sided less likely

23 than left-sided?

24 A Mural endocarditis of the right side

25 includes a lot of lesions that are brought in with foreign

1 bodies, a catheter tip, pacing lead. I mean, those sorts
2 of things where they become infected can create mural
3 lesions.

4 Q Do you think that's what happened here?

5 A I don't believe he had any of those
6 appliances.

7 Q Well, back to where I was, is right-sided
8 mural less common than left-sided mural?

9 A I don't believe I know the answer to
10 that.

11 Q Same question on the polymicrobial. Is
12 that less common within the realm of mural endocarditis
13 than a single cause?

14 A I don't believe I know the answer to that
15 either.

16 Q Certainly in the nonmural endocarditis,
17 it is true, is it not, that polymicrobial is less common
18 than single microbial?

19 A Yes, that is true.

20 Q How many patients do you think you have
21 seen, on autopsy or otherwise, that have had a mural
22 endocarditis?

23 A Including ones that were not subsequently
24 demonstrated to be infective, I'd say several dozen; but
25 infected, very rare, handful maybe.

1 Q This was infected, in your opinion;
2 correct?
3 A Yes. Oh, yeah.
4 Q So a handful of infective mural
5 endocarditis you've seen?
6 A Yes.
7 Q Can you break it down any further on how
8 many of those handful were polymicrobial versus not?
9 A I cannot specifically remember another
10 case of polymicrobial.
11 Q When you put all these things together,
12 the polymicrobial and the one side versus the other and the
13 bugs and ail that, it is a very rare condition that he had,
14 in your opinion, is it not?
15 MR. RUF: Objection.
16 A I believe so.
17 Q If one makes a study of mural
18 endocarditis in the literature, is that typically found in
19 debilitated or immunosuppressed patients, rather than
20 otherwise healthy, young adults?
21 A I believe that's correct, yes.
22 Q Where would you put Mr. Gonda in that
23 category?
24 A I don't believe he was immunosuppressed.
25 Q And certainly there was no evidence that

1 he was debilitated?

2 A Until the terminal events, yes.

3 Q So this disease, the mural endocarditis,
4 when it's found, it's normally not found in the age group
5 and the health situation of this gentleman; correct?

6 A Correct. The reported cases, I believe,
7 are not this sort of scenario.

8 Q Are there certain risk factors for the
9 mural that we need to cover, or would those fall within the
10 same risk factors or predisposing factors that you were
11 asked about for bacterial in general?

12 A Well, you mentioned the immunosuppressed
13 patient. I believe that most of the reported cases of
14 mural endocarditis that have been reported are in cancer
15 patients on chemotherapy and are usually fungal infections
16 of the wall.

17 Q Is mural endocarditis normally a fungal
18 infection?

19 A I'm not sure I know how to answer that
20 question. It's such an unusual disease, to say normally
21 is, you know -- when you have an infective lesion adhering
22 to the wall, it's whatever the infection is that you can
23 demonstrate.

24 Q I guess if you take all mural
25 endocarditis patients, will most of them have a bacteria

1 causing it or a fungus causing it?

2 A I don't believe I know the answer to that
3 question. I mean, I told you that the one paper which I
4 believe was written by a fellow named Roberts about mural
5 endocarditis who described some patients at the National
6 Cancer Institute, all of those were NCI patients. I mean,
7 they were all on protocol for some terminal malignancy, and
8 they -- I believe nearly all of them had fungal
9 endocarditis, but that is not --

10 Q You mentioned earlier the -- before I get
11 to that, where do you think the infection started here in
12 the body, Doctor?

13 A That is hard to know, because
14 symptom-wise, he seems to have been complaining of things
15 in his head and neck. But, unfortunately, the head and
16 neck are things that are not autopsied, and we may never
17 know for sure.

18 Q I take it you can't say to a reasonable
19 medical probability where it started; is that correct?

20 A I believe to a reasonable medical
21 probability it was somewhere in the head and neck, because
22 he had an autopsy that appears to have addressed most of
23 his internal organs and came up with nothing in particular.
24 There are no complaints in the arms and legs and joints
25 that we could point to, so it's vague and I believe

1 incomplete, but that's a standard defect in autopsies. We
2 don't normally examine the head and neck for funeral
3 reasons.

4 Q When you looked at the article from the
5 Cleveland Clinic on fibrosis --

6 A Yes.

7 Q -- were you aware of that article before
8 you got involved in this case?

9 A No, I believe that article was sent to me
10 from one of the authors through Mr. Malik.

11 Q Okay. Had you reached the conclusion
12 that this was not fibrosis before you had seen that
13 article?

14 A Yes.

15 Q In your medical training, had you studied
16 endomyocardial fibrosis?

17 A I had certainly heard of it. It's kind
18 of on the list of diseases when you are working up a
19 differential diagnosis for a patient with an unusual
20 ventricular lesion. It also is something that is usually
21 dismissed, simply because of its geographic nature and
22 rarity, but something you should think about when you have
23 a patient that has been in those areas or is from those
24 areas.

25 Q So when you talked to two of your

1 colleagues here, the husband-and-wife team, you did that
2 before you were aware of the article from the Cleveland
3 Clinic; right?

4 A I don't recall the order of those events,
5 to be honest with you. This has been going on a long time
6 now.

7 Q Jumping around here a little bit, a
8 question that Mr. Travers asked you, I have down here most
9 endocarditis patients don't present with the type of
10 ventricular lesion that this gentleman had. Is that a
11 correct statement?

12 A That's correct.

13 Q What is it about this ventricular lesion
14 that is -- maybe we've already covered this.

15 A I'll repeat it.

16 Q -- that's different from what is normally
17 presented in an endocarditis patient?

18 A First of all, it is not involving the
19 valves specifically.

20 Q I got that.

21 A Well, that's the most important.

22 Q Okay. I understand. On the fibrosis
23 condition, doesn't that typically involve the apex -- is
24 that the right word in the singular -- of the ventricle?

25 A Yes.

1 Q Did this, in your opinion, involve the
2 apex?

3 A No.

4 Q That's why I was confused. I took it
5 from the autopsy that it had some involvement.

6 A No. From the photographs and also from
7 the autopsy description, this lesion is described as lying
8 in the ventricular outflow tract, which is a basal
9 structure.

10 Q Page 4 of the autopsy, where it starts,
11 in the right ventricle --

12 A I'm sorry, I'm not with you yet.

13 Q About halfway down on the page.

14 A Okay, here we go.

15 Q Says, in the right ventricle there is a
16 soft, friable, white-colored mass which extends from the
17 apex of the ventricle to within .5 centimeters of the
18 pulmonary valve. Do you take that to mean that there is
19 involvement with the apex?

20 A Not necessarily.

21 Q Why?

22 A Very often, actually, virtually always,
23 in autopsy, there will be clotted blood in the chamber of
24 the right ventricle. And, you know, one of the important
25 things that an experienced pathologist develops is an

1 appreciation for what is actually real, that is a
2 significant pathologic lesion, and that which is postmortal
3 thrombus. And the fact that somebody found a white-colored
4 lesion in the chamber of the heart could be very easily
5 explained as it's just postmortal thrombus. In this case,
6 it's difficult to assess that specific statement
7 independently. I think much more reliable information are
8 the photographs.

9 Q And you're relying in part on the
10 photographs showing no apical involvement?

11 A That's correct.

12 Q How many photographs were there, do you
13 recall?

14 A Of the heart, two.

15 MR. MALIK: I have a quick question.
16 Did you say you're an M.D.?

17 MR. FRASURE: No. This fellow over
18 here is.

19 MR. MALIK: I thought you said Dr.
20 Mark Frasure.

21 MR. TRAVERS: No. Doctor --

22 MR. FRASURE: Doctor, Mark Frasure.

23 I think I was saying Doctor, comma, I'm Mark Frasure.

24 A I didn't think you were a doctor.

25 Q You could tell; right? You had two

1 photos of the heart?

2 A Correct.

3 Q Would you expect to see the finding on
4 the gross exam that is in the Autopsy Report about there
5 being a soft, friable mass which extends from the apex,
6 would you expect to see that finding on a case involving
7 bacterial endocarditis, that gross description that I just
8 read there?

9 A I wouldn't expect it, no. I would expect
10 to see valvular lesions, is what I would expect to see.

11 Q So that description I read, you're saying,
12 then, that that is inconsistent with the photographs?

13 A Yes.

14 Q Okay. Can the autopsy pathologist see
15 certain things that are not contained within the
16 photographs?

17 A Yes. An inexperienced person can do a
18 tremendous amount of damage to vegetations and such.
19 They're very fragile, and, you know, if they got torn off
20 before the photograph, I suppose that we might not see
21 them.

22 Q Let me ask you, what is it about the
23 Cleveland Clinic pathology that you think was so
24 unreasonable? Was it what they didn't examine, or was it
25 their conclusions, or did they examine the right things,

1 did they -- was the procedure improper? What is it that's
2 unreasonable?

3 A I cannot comment on the procedure,
4 because I really was not there for that. In order to most
5 properly address this kind of a case, one has to have very
6 good attention to the condition in which the cultures are
7 taken. My biggest reservation are the findings that were
8 overlooked. The findings in the lungs, I believe, are
9 grossly understated in the Autopsy Report.

10 Q And those are, just so I'm clear, are
11 what?

12 A I believe that the abscess, the
13 vasculitis, the septic embolism, those are just such
14 red-flag conditions that just --

15 Q Septic embolism?

16 A Yes.

17 Q Those are red-flag conditions for
18 bacterial endocarditis?

19 A Well, for a very acute disease that needs
20 to be explained. And it just looks to me as though they
21 got on this primrose path of some unusual disease and
22 proceeded to pound that square peg into a round hole.

23 Q Were there any photographs of the heart,
24 Dr. Hoffman, that you saw?

25 A Yes, I just told you there were two

1 photographs of the heart.

2 Q The lungs, I'm sorry.

3 A Yes, there was at least one photograph of
4 the lung, I believe one.

5 Q Do you find any of these things that you
6 mentioned, abscesses, vasculitis, septic embolism on photos
7 of the lung?

8 A It's not possible to identify them as
9 such, necessarily, on the photographs. But in the context
10 of the microscopic slides, it's very clear that that's what
11 they are.

12 Q And can you point to me in the Autopsy
13 Report where you believe this is grossly understated so I'm
14 clear I understand what you mean?

15 A Well, in the final diagnoses, they talk
16 about multiple thromboemboli to both lungs. Now, reading
17 that report --

18 Q What page are you on?

19 A I'm on the front sheet, Page 1.

20 Q Okay.

21 A That implies to the reader that these are
22 sort of garden-variety thromboemboli, bland thromboemboli
23 as might arise in the leg veins of an old lady, break
24 loose, and be found in the lung. This is not the picture
25 of septic thromboembolism that we're seeing here, and

1 believe me, I see lots and lots of these things. These are
2 probably the most common, garden variety -- garden
3 thromboemboli are probably the most common surprise finding
4 at autopsy, They're always way up on the list, and we
5 spend a lot of time discussing those with our residents.
6 You know, they describe parenchymal lesions, a remote and
7 acute pulmonary infarct, and diffuse alveolar damage.

8 Well, it really falls short of describing the acute
9 nature of what's going on. We have a process that is
10 literally creating pus that is working its way through one
11 of the pulmonary arteries, several of the pulmonary
12 arteries, I presume, and causing this fellow to be coughing
13 up blood. Pulmonary hypertension, Grade 3, that's just
14 barking up the wrong tree. I mean, that's --

15 Q Are you saying you don't find these lung
16 final anatomic diagnoses supported by the gross description
17 narrative?

18 A No, I'm saying my findings just do not
19 agree here.

20 Q Your findings on slides?

21 A My findings on slides do not match what
22 I'm seeing here. These are things that --

23 Q Are your findings on slides more serious
24 for the lung --

25 A Yes.

1 Q -- you're saying?

2 A Much more serious.

3 Q And if that's true, does that point away
4 or toward or have no effect on whether it's a fibrosis or
5 an endocarditis?

6 A I think it makes it less likely that it's
7 endomyocardial fibrosis.

8 Q And more likely that it's endocarditis?

9 A Yes.

10 Q Why?

11 A Because in endomyocardial fibrosis, you
12 would not expect to see this rip-roaring, acute
13 inflammatory process going on.

14 Q That would involve the lungs?

15 A The lungs or the heart.

16 Q And in mural endocarditis, is this kind
17 of, as you say, rip-roaring process going on? Is that
18 typical in mural endocarditis?

19 A Yes.

20 Q Is the definition of mural endocarditis
21 that it does not involve valves?

22 A Not specifically. It's that it does
23 involve the wall of the chamber.

24 Q So some mural endocarditis does involve
25 the valves?

1 A It is conceivably possible. Mural means
2 the wall. Mural means wall, so that really is the
3 definition.

4 Q Well, can we agree that the person at the
5 Cleveland Clinic realized on gross examination that this
6 disease, whatever it was, did not involve the valves;
7 correct?

8 A That seems reasonable, yes.

9 Q And that tends to point one away, to
10 start with, from endocarditis, doesn't it?

11 A Yes.

12 Q Okay. At that point, was endocardial
13 fibrosis a reasonable differential diagnosis to entertain?

14 A I suppose, for the sake of completeness,
15 I would have to say yes, that you want to, in a
16 differential diagnosis, you want to cast a broad net.

17 Q Did you rule out endocardial fibrosis
18 because you were not aware of any occurring in America?

19 A No. No, I was aware of the entity, but
20 looking at these slides, this was a hot, inflammatory
21 process

22 Q It doesn't match -- in your opinion, the
23 slides don't match the presentation of an endocardial
24 fibrosis?

25 A That is my impression.

1 Q Are there any advantages that the
2 Cleveland Clinic personnel had over you in that they saw
3 the tissue come out, rather than just photographs? Is that
4 of some advantage?

5 A Yes, it is. I mean, it would be a
6 tremendous advantage, really, to be able to, you know,
7 perform the autopsy yourself.

8 Q Going back to the autopsy at the Clinic,
9 you've told me you think they grossly understated the lung
10 involvement. Going back, do you think the process, the way
11 they did it, or can you not tell from how they describe it
12 whether the process is accurate or reasonable?

13 A I really cannot comment on that.

14 Q Let me ask you this.

15 A I don't know the process that they used.

16 Q When you read the autopsy, did it read
17 like an autopsy would typically read, the process they go
18 through? Was there something missing, was there --

19 A Their protocol, this report is
20 reasonable. It is conspicuously lacking a section that I
21 think is important called microscopic descriptions, where
22 you say what it is you saw on the slides. I would have
23 just loved to have seen that, because I just can't imagine
24 how they could not have described the inflammatory process
25 that was going on.

Q Okay. When you went over to the Clinic, did anyone, any pathologist, look with you at anything?

a No.

Q And what did you look at there?

A I believe we had access to all of the slides from the case, except for No. 16, which still at the time was missing, but which was subsequently sent to me.

8 Q If this would have occurred, let's say,
9 in your hospital, if this same report would have occurred,
10 come out of your hospital by someone, not yourself, but
11 someone else, and someone else read it at another hospital
12 in town and felt that this was an unreasonable report,

13

14

15

16

17

18

19 phone call, perhaps a letter.

20 Q Are there protocols set in place in this
21 hospital that if you are informed of that, that it comes to
22 the supervisor's attention, and it's looked into to see if
23 there's any merit in the criticism?

24 A Yes.

25 Q Did you do that vis-a-vis the Cleveland

1 Clinic here?

2 A Not yet. Understanding that this case is
3 in litigation, I thought it was most prudent not to raise
4 that issue.

5 Q But the Cleveland Clinic --

6 A I believe that they will be made aware of
7 this process.

8 Q So that's the reason you haven't told
9 anyone at the Clinic, is because the case is in litigation?

10 A That is my assumption.

11 Q You learned in, what, late '97 that your
12 opinion -- you developed your opinion that this was not
13 fibrosis in the October range of '97?

14 A That's right, yes.

15 Q Is endocardial fibrosis the same as
16 endomyocardial fibrosis? I've seen it called two different
17 things.

18 A I believe that the disease that is
19 described in Africa is uniformly described as
20 endomyocardial fibrosis. That is a disease entity.
21 Endocardial fibrosis could just be a description. It's
22 hard to know.

23 Q Mr. Travers asked you about two
24 sub-categories of mural endocarditis, and I want to see if
25 I have these correctly. One is overlying a disease of the

1 myocardium, and you believe that was not present here?

2 A I believe that's right, yes.

3 Q And the other sub-category is an embolism
4 of infected material going to the heart and lungs?

5 A Yes.

6 Q And you believe that's probably what was
7 present here?

8 A Probably.

9 Q Okay. Do you think this was an anaerobic
10 infection that came from the head and neck?

11 A Well, I mean, the organisms that we have
12 to look at and the polymicrobial nature suggest anaerobic
13 infection, yes.

14 Q Of all the infections that develop in the
15 head and neck, are anaerobic less common than the
16 nonanaerobic, if that makes sense?

17 A Well, I'm not certain what the answer
18 would be.

19 Q Is that outside your area of expertise?

20 A I believe that's outside my area of
21 expertise.

22 Q More in the area of infectious disease?

23 A Right.

24 Q Did you find some organisms here in the
25 lung that were not, apparently, found in the heart? I'm

1 unclear on that.

2 A I have not done any special stains on the
3 lung tissue, I don't think. I've looked at the heart
4 pretty carefully, but I don't believe I've spent time on
5 the lung.

6 Q Do you anticipate doing anything else,
7 Doctor, as far as reaching any conclusions here, or have
8 you --

9 A I don't believe I have anything else,
10 really, to do. If any additional information arises, I
11 would be very happy to see it. This is a very fascinating
12 case.

13 Q Based on the information you have, you
14 don't see there's any need to do anything further medically
15 to support or not support your opinion; am I correct on
16 that?

17 A That's correct.

18 Q On the second page of your latter report,
19 before you start into the anatomic diagnoses, you mention
20 there's a possibility there might have been contamination
21 of the autopsy lung culture?

22 A Yes.

23 Q Could you explain that to me, please?

24 A Well, as soon as somebody dies, the
25 barrier that usually contains the flora that normally

1 inhabits the intestinal tract breaks down, and you have
2 hematogenous seeding of the whole body with gut flora.
3 Usually if death has occurred less than 24 hours before
4 autopsy, that is not a significant factor.

5 Any culturing performed at autopsy, however, has to be
6 performed properly in order to avoid contamination during
7 the process of culture. And we employ a variety of steps
8 in order to maximize the possibility of getting a useful
9 culture. For example, after the body cavities are opened,
10 the very first thing that should happen is culturing. And
11 I just don't know, based on the standards or procedures
12 used at the Cleveland Clinic, whether or not that occurred.

13 Another thing that should happen is that, particularly
14 in taking a culture of the lung, we're not interested in
15 sampling the pleural surface of the lung. We're most
16 interested in sampling deep into the culture of the lung.
17 And in order to get a culture that's uncontaminated by
18 pleural surface flora, the pleural surface has to be
19 decontaminated. That's done usually with a hot spatula.
20 You simply burn the surface with a red-hot spatula and make
21 an incision through the seared surface with a sterile
22 blade, put the sterile culture into the lung tissue, and
23 obtain the sample that way.

24 Q And you're saying you don't know if any
2e of that was done here or not?

1 A I have no indication. I sincerely hope
2 that that is the standard of practice at Cleveland Clinic.
3 From everything I know of their department, they
4 probably do things in a reasonable fashion, and that is my
5 expectation here. So I have to interpret it with that
6 caveat.

7 Q So when you say there is a possibility of
8 contamination caused by suboptimal technique, you don't
9 know there is any. You're saying that is always a
10 possibility?

11 A I'm just being fair. I'm just trying to
12 explore all possibilities.

13 Q Then you give another possible cause of a
14 possible contamination, that being overgrowth of the
15 intestinal flora postmortum?

16 A Correct.

17 Q Can that occur even in the absence of
18 suboptimal technique?

19 A Yes, it can. But, again, it's unlikely,
20 based on the relatively short postmortum interval here.

21 Q I guess I'm confused on what developed
22 from the cultures that you believe show that this is a
23 polymicrobial endocarditis. Where do you draw that from,
24 from cultures that were done at the Clinic?

25 A Yes.

1 Q Found in the lung or the heart?

2 A In the lung. The cultures, apparently,
3 were taken from the lung, and those are the only cultures I
4 know of in this case.

5 Q Okay. What's your explanation for why
6 these would not have grown from the heart?

7 A Because they were never sampled,
8 apparently.

9 Q So you're saying apparently never any
10 cultures from the heart?

11 A That is the impression I gained from
12 reading the report.

13 Q And if that's true, is that suboptimal
14 technique, in your opinion?

15 A Well, in trying to be fair to the people
16 who were performing this case, who were probably relatively
17 inexperienced, they may not have thought this looked like
18 endocarditis, and therefore said we don't have to culture
19 it. I think anytime -- I tell my residents if they find a
20 lesion that looks like an abscess or an infected focus,
21 even though it's well into the autopsy, after they've taken
22 their routine surveillance cultures, that they should
23 probably get a sample of it up to microbiology simply just
24 to cover their tail, if you will.

25 Q Okay. Do you know if there's often a

1 thrombus found to be present in myocardial fibrosis or
2 endocardial fibrosis?

3 A I believe it can occur, yes.

4 Q And was a thrombus present here?

5 A There is thrombus present, yes.

6 Q If there is such an acute inflammatory
7 process going on, why were the stains negative for
8 organisms on Slide 13?

9 A Well, if the patient has been treated
10 with antibiotics, partially treated with antibiotics, they
11 may not be very visible. Certain anaerobic organisms do
12 not like to be exposed to air and break down fairly quickly
13 on exposure to air. That's a possibility. Gram negative
14 organisms, in general, are much more difficult to detect on
15 even good gram stains, simply because they just shake out a
16 lighter color, There's a variety of reasons. You don't
17 need to have a whole lot of infection in order to entertain
18 a diagnosis of infective endocarditis.

19 Q Now, you did your gram stains when you
20 first got the slides?

21 A I believe it was on the second round.

22 Q So we've got about two years from the
23 time of the autopsy; right?

24 A Yes.

25 Q Does the passage of two years affect the

1 reliability at all of your gram stains?

2 A I don't believe so, no. The tissue has
3 been embedded in wax all that time, so there's really no
4 contact with air. They were cut freshly.

5 Q You found gram negative bacilli in your
6 stains?

7 A Yes.

8 Q How many types of bacteria qualify as
9 gram negative?

10 A That's a long list.

11 Q Can you be sure the bacteria you found
12 were the same as in the lung?

13 A No, not certain, but I believe that's
14 reasonable to tie the case together. It's the same heart
15 and the same lung.

16 Q Are there many different types of gram
17 positive bacilli?

18 A Yes.

19 Q Can you be sure the gram positive
20 bacteria you found were the same as in the lung?

21 A The same answer again.

22 Q Why weren't the other organisms that were
23 seen in the lung culture, why were they not found in your
24 stains of the heart?

25 A I do not know.

1 Q Can this be because of contamination?

2 A That is a possibility.

3 Q If that's true, then would we have some
4 organisms found in the lung were contaminated and some were
5 not due to the contamination?

6 A I suppose that has to be possible, again,
7 reiterating that I do not know anything about the specific
8 procedures that were used in performing the autopsy, only
9 assuming they are reasonable procedures.

10 Q You mentioned the finding of severe acute
11 necrotizing arteritis in the pulmonary arteries. What time
12 frame are you talking about do you believe that was
13 present?

14 A I don't think more than several days.

15 Q Speaking of more than several days before
16 the death?

17 A Yes, before the death.

18 Q Just so I'm clear here, you've described
19 what you found at autopsy, what you found that you believe
20 was present at autopsy?

21 A Yes.

22 Q Are you using any of the events of Mr.
23 Gonda's life and his medical care and his presentation to
24 support your diagnosis, or are you basically just going on
25 what's found at autopsy? In other words, are you trying to

1 correlate the clinical and the anatomical or just the
2 anatomical?

3 A Well, I have to interpret it in the
4 context of the clinical presentation. So I guess I do have
5 some input from the clinical presentation. He certainly
6 had some complaints that preceded his death, and I believe
7 I've noted those.

8 Q Do you have any opinion on how long one
9 can live with an acute mural endocarditis, which you
10 believe this gentleman had?

11 A I wouldn't speculate.

12 Q You mentioned that the pulmonary infarcts
13 here were no more than a few days old. What's the
14 significance of that, being no more than a few days old, if
15 any?

16 A I just believe that that's a piece of
17 information that can be surmised from the appearance of the
18 tissue. It may give us some indication of the time course
19 of the disease process that's going on.

20 Q Do you know if people with endocardial
21 fibrosis ever develop endocarditis?

22 MR. RUF: Objection.

23 Q Have you ever heard of that?

24 A I suppose it is possible.

25 MR. FRASURE: Okay. Let me pass to

1 Mr. Blomstrom here, and I may have a few more later.

2 CROSS EXAMINATION:

3 By Mr. Blomstrom

4 Q When you were working through your part
5 of this file, did you make any notations, whether oral, by
6 dictation, or by your hand or by typing, of your findings
7 on your view of the microscopic slides?

8 A I may have made some notes of, you know,
9 the slides and what I saw. I have discarded those, I
10 believe, and have summarized those in the report that I've
11 provided here.

12 Q You don't have any notations of your
13 findings on individual slides; is that how I'm to interpret
14 what you're saying?

15 A There was findings on individual slides
16 summarized in the report that I provided.

17 Q All right.

18 A I think I've been very careful about
19 that.

20 Q Aside from the two reports that we've
21 seen, that being October of 1997 and what we now know to be
22 March of 1998, do you have any notations, either with you
23 or elsewhere, of your findings on interpretation of
24 individual slides?

25 A I'm not certain that I do. No. I mean,

1 I've tried to make this my report.

2 Q Are you certain that you don't?

3 A No, I'm not, actually.

4 Q If you have them, where would they be?

5 A I presume in my office.

6 Q Do you have a portion of records
7 concerning this case in your office?

8 A Yes.

9 Q What do you have in your office that you
10 haven't brought with you today?

11 A I have a transesophageal echocardiogram
12 tape. I have glass slides that were provided to me from
13 the Cleveland Clinic that were stained there. I have some
14 unstained slides. I have the stains that we performed here
15 on some of those. I have some library research. I have
16 some -- what else? I believe I have some computer disks
17 that have the -- you know, these reports on them. I think
18 that's the substance of what I have.

19 Q Is that all of what you have?

20 A I think that's everything, yeah. Is
21 there some specific thing that I'm --

22 Q No, I'm just being --

23 A You're being an attorney, okay.

24 Q No, I'm not being an attorney, I'm
25 just -- as an old English major, I am trying to be aware of

1 the nuance of language that you're using so I'm seeing what
2 may be there.

3 A I think that's everything. I have the
4 expert reports that I've shown you here. I mean, that --

5 Q All right. Can you describe for us what
6 you would expect to be the natural history of the
7 polymicrobial endocarditis which you believe that Mr. Gonda
8 had?

9 A The natural course?

10 Q What would you expect to be the natural
11 history of that type of polymicrobial endocarditis?

12 A Untreated, you mean?

13 Q Yes.

14 A I believe it would have resulted in
15 death.

16 Q Given the interventions that Mr. Gonda
17 had, which was essentially the prescription of the
18 antibiotics that he did receive, what would you expect to
19 be the natural history of that type of polymicrobial
20 endocarditis? I'm not looking at you would expect it to
21 end up in death, but what stages would he go through?

22 A I don't think I can comment, from the
23 standpoint that I am not an expert on the nuances of the
24 treatment that is used for this type of disease or the
25 types of diseases they may have suspected that he had.

1 Q All right.

2 A However, knowing my diagnosis of the
3 final outcome, I would have expected that he would have had
4 a chronic febrile illness that terminally would have ended
5 in a respiratory symptom complex, that dyspnea would figure
6 very prominently, and that respiratory hemorrhage would be
7 a very important component of the terminal course.

8 Q I gathered from your testimony earlier
9 that, as far as the initial cause of his problem is
10 concerned, you would expect that he would have had a
11 febrile course from that before he developed the
12 endocarditis; correct?

13 A Yes.

14 Q So the fact that he has a fever or not is
15 not necessarily an indication of the onset of endocarditis;
16 correct?

17 A I suppose that's true, yes.

18 Q And to your belief, you think that he
19 probably had a cause that was infective arising in the head
20 and neck; correct?

21 A That's where his complaints were.

22 Q What type of illness or pathological
23 process would you expect for him to have in those areas
24 that could give rise to a polymicrobial endocarditis?

25 A A pharyngitis, you know. I don't think

1 there's any indication of it, but I suppose a dental
2 abscess is a possibility. An ear infection, a possibility.
3 A tonsillitis. I mean, this is just -- it's a variant of
4 pharyngitis, but that situation. There are -- I've seen
5 young people die from retropharyngeal abscess. Again, we
6 don't have any indication of what was going on up there at
7 the time.

8 Q You've mentioned cultures done at the
9 Cleveland Clinic. Can you locate those cultures for me?

10 A Okay.

11 Q May I see them, please?

12 A Certainly.

13 Q Since I don't have a copy of these, I'm
14 going to ask the court reporter to mark this, and one way
15 or the other, either she can take it and get this back to
16 you or --

17 (Whereupon Defendant's Exhibit A was marked.)

18 Q I gather that it's fair to say that your
19 interpretation of the slides is not consistent with the
20 gross description of the cardiovascular and respiratory
21 systems found in the Autopsy Report; is that correct?

22 A I believe that my findings are consistent
23 with what is reported here.

24 Q Your findings are consistent with the
25 gross descriptions of the cardiovascular system and the

1 respiratory system, just so that I understand; correct?

2 A They are reporting a mass in the left
3 ventricular outflow tract, which I do not dispute. I see
4 something that I would presume would be interpreted as a
5 mass. And they are seeing white, friable material in the
6 pulmonary vasculature, which I presume the gross findings
7 in the condition that I have described would look something
8 like white, friable material. I mean, they don't have
9 microscopic resolution, as they would have in examining the
10 slides. I have no problem with what they think they've
11 seen grossly. I just think they've misinterpreted it.

12 Q Well, earlier I think you told us -- if
13 you didn't, please tell me that I'm wrong -- that your
14 findings on the slides do not match what you are seeing in
15 the gross description on the report. And now you're saying
16 that they're consistent. So how is it that they cannot
17 match but be consistent?

18 A The findings that I see on the slides I
19 diagnose as -- I am coming up with diagnoses, can I
20 understand that that may be what they thought they saw,
21 yes. So in that way, I suppose it is consistent.

22 Q Well, then, what did you mean when you
23 earlier said that your findings on the slides do not match
24 what you were seeing on the gross description?

25 A Perhaps I was taken out of context, but

1 the slides that I'm seeing show an acute inflammatory
2 process that I interpret to be infective in nature. The
3 gross description is talking about a mass. Sort of sounds
4 like tumor. I know, because I have the benefit of looking
5 at it under the microscope, that it is not just a mass, but
6 it is, in fact, an inflammatory process representing an
7 infection.

8 I can also understand that an individual performing
9 the autopsy, without the benefit of microscopy yet, that is
10 at the point when they do the gross description, might very
11 well describe what is described here. So I don't think
12 those are particularly contradictory statements.

13 Q On the gross description in the Autopsy
14 Report, under the cardiovascular system, now, if I
15 understand what you said earlier correctly, the friable,
16 white-colored material there you think may simply be clot
17 or blood; correct?

18 A Yes.

19 Q Underlying that, they describe a mass 3.5
20 by 1.5 by .3 centimeters; correct?

21 A Okay.

22 Q How much of that represents the
23 inflammatory process?

24 A That underlying material is the
25 inflammatory process, to the best of my understanding.

1 Q Where, with respect to the inflammatory
2 process, is the fibrosis that you found or that was found?

3 A Underneath it. It is deep, away from the
4 lumen of the right ventricle.

5 Q So that entire mass here is inflammatory
6 process, and the fibrosis is really within the heart wall;
7 correct?

8 A Right.

9 Q With respect to the inflammatory mass,
10 then, is that the same thing that you said is the luminal
11 face that was very fresh?

12 A Yes.

13 Q And you may have said how long that was
14 there. Is that what you were referring to being there as a
15 matter of days?

16 A Yes.

17 Q And by a matter of days, you don't mean
18 so much as a week; right?

19 A That's -- yes. I mean, I say days so as
20 not to say weeks or months or minutes or hours.

21 Q But just so that we're not clear -- just
22 so that we get clear, okay -- I don't think we're clear
23 yet, but I want to get clear -- you're not saying that the
24 length of time that that inflammatory process was there
25 exceeded seven days, are you?

1 A The part of the process that we perceive
2 as scarring, endocarditis, you know, on the surface of it,
3 has to have been there for at least several weeks.

4 Scarring takes time to develop.

5 Q That's the part that's within the wall?

6 A That's the deep part.

7 Q Correct?

8 A The more superficial parts of it are
9 apparently much fresher, and, again, it's a gradient.
10 There are different stages of a process going on, the most
11 recent of which appears to be very, very fresh.

12 Q Thank you for your statement, but let's
13 try one more time. Is it true that this inflammatory mass
14 which you said accounts for the 3.5 by 1.5 by .3 centimete
15 mass, was there less than a week prior to death?

16 A That part of it, yes.

17 Q Now, you said that the underlying
18 fibrosis within the wall or the scarring would have been
19 there several weeks, in your view; correct?

20 A Yes.

21 Q So let's go through the same exercise fo
22 several weeks.

23 A Okay.

24 Q Not the exercise, but the term.

25 A Okay.

1 Q How long is several weeks, in your
2 estimation? I want to get an outside estimation as to how
3 long you're saying that was there.

4 A Outside?

5 Q Outside.

6 A The oldest part of that may have been
7 from birth. I mean, there is no upper end.

8 Q That certainly covers it, but --

9 A Scarring is sort of an end stage, and
10 once it gets to a certain point, you just can't tell.

11 Q How much scarring was there, then, do you
12 have a measurement? Do you have another way of quantifying
13 it for us at the time of the autopsy?

14 A I did not have the benefit of being able
15 to measure it in the gross, and I would have to have the
16 slides in front of me in order to do it based on the
17 microscopy, with a whole lot of caveats based on shrinkage
18 of the tissue and sampling and other things. The gross is
19 really the best way to have that measurement. I don't
20 believe, based on my recollection, that it involved the
21 entire thickness of the wall.

22 Q On, I think, the 16th or the 17th of
23 August, there was a 2-D echo followed by a TEE done
24 concerning this young man's heart. And that TEE refers to
25 a prominent mobile right ventricular mass. Do you recall

1 seeing that?

2 A I recall seeing that, yes.

3 Q All right. Now, this prominent right
4 ventricular mass, was that the inflammatory response?

5 A It might be the inflammatory response.
6 It may be blood clot adherent to that.

7 Q So the inflammatory response may have a
8 blood clot adherent to it?

9 A Yes.

10 Q And that inflammatory response would have
11 to be there before the blood clot could be adherent to it;
12 right?

13 A Reasonably, yes.

14 Q I'm very close to the end, if you'll bear
15 with me just a minute.

16 A Certainly.

17 Q With respect to the actual immediate
18 cause of death, if I understand you correctly -- and please
19 correct me if I'm wrong -- the pulmonary vasculitis that
20 existed led to an erosion, if you will, of the wall of the
21 artery, which led to the bleeding that caused his death; is
22 that right?

23 A That's correct.

24 Q You referred to the lung abscesses as
25 septic thromboembolism. How did you come to the conclusion

1 that the thromboemboli were septic in themselves?

2 A An extension of the extreme amount of
3 inflammation. Thromboemboli in the lung, garden variety,
4 things we see all the time in little old ladies that
5 suddenly die, do not have nearly this degree of
6 inflammation, and the inflammation certainly does not go
7 eroding through the wall of the blood vessel. This is a
8 red flag.

9 Q The word septic is an inference from what
10 you did see; right?

11 A Yes.

12 Q You referred to some slides as being hot,
13 but you didn't indicate which slides. Which slides were
14 hot?

15 A I used the term hot to describe --

16 Q I know how you used the term hot. Which
17 ones?

18 A Not to imply that they have been obtained
19 by illicit means. I've got all these attorneys here. The
20 acute inflammation, as I've described it, I would describe
21 as hot. So the slides that I have indicated on my report,
22 11 through 16, inclusive --

23 Q Okay.

24 A -- 7 and 10, at least those. I'm not
25 certain I can say about the others.

1 MR. BLOMSTROM: Thank you.

2 THE WITNESS: You're welcome.

3 RECROSS EXAMINATION:

4 By Mr. Travers

5 Q Dr. Hoffman, the septic thromboembolic
6 invasion of the pulmonary arteries that caused the
7 patient's death was secondary to the inflammatory process
8 portion of the cardiac lesion, as opposed to the scarring,
9 was it not?

10 A I believe that's true, yes.

11 Q And there's no way to tell whether that
12 underlying scarring was a condition that had been present
13 from the patient's birth even?

14 A For what it's worth, there are scarring
15 conditions that involve the right ventricle, and, you know,
16 some are from birth.

17 Q But that's not what caused the patient's
18 death?

19 A I don't think it was.

20 Q It was the inherent inflammatory process
21 that threw the thromboemboli?

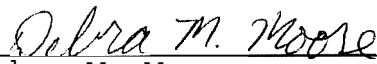
22 A That is correct.

23 MR. TRAVERS: That's all I have.
24 Thanks.

25 MR. FRASURE: Nothing further.

1
2
3
4 REPORTER 'S CERTIFICATE
5

6 I HEREBY CERTIFY that the above and foregoing is a
7 true and correct transcript of all the testimony introduced
8 and proceedings had in the taking of the testimony in the
9 above-entitled matter, as shown by my stenotype notes taken
10 by me at the time said testimony was taken.

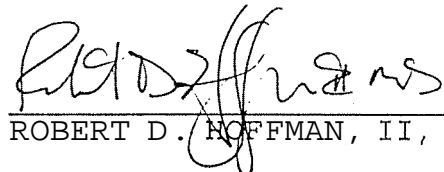
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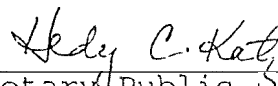
CERTIFICATE

3 I, ROBERT D. HOFFMAN, II, M.D., depose
 4 and say that I have read the foregoing deposition and find
 5 it true and correct, unless otherwise specifically
 6 excepted to and indicated on Page 115-A, and any following
 7 numbered pages thereafter, if applicable, and I subscribe
 8 my signature to the aforesaid deposition this ____ Day
 9 of January, 1998. ^{RM}
 10 1999


 ROBERT D. HOFFMAN, II, M.D.

12
 13 Before me, a Notary Public within and
 14 for the State of Ohio, personally appeared ROBERT D.
 15 HOFFMAN, II, M.D., who, being first duly sworn, deposes and
 16 says that he has read the foregoing deposition and finds it
 17 true and correct to the best of his knowledge, information
 18 and belief, unless otherwise specifically excepted to and
 19 indicated on Page 115-A, and any following numbered pages
 20 thereafter, if applicable.

21 SWORN AND SUBSCRIBED before me this
 22 4th Day of January, 1998.
 23 1999


 24 Notary Public
 25 My Commission Expires 10-07-02
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TO THE WITNESS: DO NOT WRITE IN TRANSCRIPT EXCEPT TO SIGN.
Please note any word changes/corrections on this sheet
only. Thank you.

TO THE REPORTER: I have read the entire transcript of my
deposition taken on the 8 day of DECEMBER, 1998,
or the same has been read to me. I request that the
following changes be entered upon the record for reasons
indicated. I have signed my name to the signature page and
authorized you to attach the following changes to the
original transcript:

PAGE	LINE	CORRECTION OR CHANGE & REASON THEREFOR
31	14	PRACTICE OF <u>AUTOPSY</u> PATHOLOGY (word omitted)
32	7	WANG (NAME OF PHYSICIAN)
32	23	SEING → SAYING
43	21	EOSINOPHILS → EOSINOPHILIA
69	17	FULMINATE → FULMINANT
70	19	SEATING → SEEDING
71	17	SEATING → SEEDING
82	2	POSTMORTAL → POSTMORTEM
82	5	POSTMORTAL → POSTMORTEM
94	2	SEATING → SEEDING
94	16	CULTURE → SUBSTANCE
101	15	THERE WAS → THERE ARE
106	2	LEFT → RIGHT
106		

1/4/99
Today's date

 msp
Signature of Deponent

DAVID B. MALIK Co., L.P.A.

ATTORNEYS AT LAW

THE MAY VALLEY BUILDING
8228 MAYFIELD ROAD SUITE IV B
CHESTERLAND, OHIO 440261-800-642-6677
Fax (216) 729-8262CHESTERLAND (216) 729-8260
CLEVELAND (216) 696-26501140 LEADER BUILDING
CLEVELAND, OHIO 44114

FAX

To:

DR. HOFFMAN

Fax:

844-1810

From:

David B. Mallk
David B. Malik Co. L.P.A.

Date:

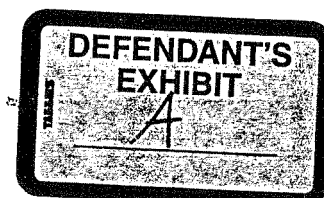
2/98

Pages:

 including cover sheet.

Comments:

Thank you!



NEW AUTOPSY INFORMATION SHEET (REQUISITION)

Post Mortem Microbiology
CLEVELAND CLINIC

AUTOPSY NO. A75-169 DATE OF AUTOPSY 8/18/95
 NAME OF DECEASED David Gorda PROSECTOR Nancy Wang
 CLINIC NO. 234719265 CLINICAL PATHOLOGY RESIDENT Dave Oh

Age: 27Clinical Summary: massive hemoptysisANATOMICAL FINDINGS: (R) ventricle intumescence

Date cultures received in microbiology: _____

Type of Specimen

- A. Lung
 B. _____
 C. _____
 D. _____
 E. _____

Specific Test Requested

- A. bacteria fungi
 B. l-aerobic - anaerobic
 C. _____
 D. _____
 E. _____

Microbiology Findings:

Specimen:

Final Report:

Resident
Notified

Bacteriology: Rare Enterococcus sp. Gramule NSE NON-SPORE FORMING
Rare Enterococcus sp. Gramule NSE NON-SPORE FORMING
Rare Yeast sp. Gramule NSE NON-SPORE FORMING
Saccharomyces cerevisiae Gramule NSE NON-SPORE FORMING

Mycology: PHIOGLYCANTIC No other Fungus Found 9-15-95
Few Saccharomyces cerevisiae 9-15-95

AFB

Date
Initial

Virology

Date
Initial

Other

Date
InitialDate Reported to Anatomic Pathology 11/29/95 Signed Flavore Elgar

2-347-926-5

THE CLEVELAND CLINIC FOUNDATION
DIVISION OF PATHOLOGY AND LABORATORY MEDICINE
DEPARTMENT OF CLINICAL PATHOLOGY
3300 KULICK AVENUE CLEVELAND, OHIO 44106
LABORATORY REPORT

PAGE 1
08/10/95
21:35

PATIENT LOCATION: 051-11
NUMBER: 2-347-926-5
NAME: GONDA, DAVID
AGE: 27Y
SEX: M
CATEGORY: 0

PRIMARY PHYSICIAN: 00705 WIEDENMANN, HERBERT P

ADMIT DATE: 08/17/95

DISCHARGED: 08/18/95

***** SERUM CHEMISTRY SURVEY *****

	TP	ALB	CA	PHOS	URIC A	T BILI
REF. RANGE:	6.0	3.5	8.5	2.5	3.0	0
	8.4	5.0	10.5	4.5	8.0	1.5
UNIT:	G/DL	G/DL	MG/DL	MG/DL	MG/DL	MG/DL
DATE TIME						
0817 2025	5.7*	3.0*	8.2*	3.0	3.6	1.1
0818 0200	5.3*	3.1*	7.8*	3.3	3.3	1.2

***** SERUM ELECTROLYTES *****

	GLUCOSE	NA	K	CL	CO2	BUN	CREAT	HA
REF. RANGE:	85	135	3.5	98	24	10	0.7	135
	110	145	5.0	108	32	25	1.4	145
UNIT:	MG/DL	MMOL/L	MMOL/L	MMOL/L	MMOL/L	MG/DL	MG/DL	MMOL/L
DATE TIME								
0817 2025	125*	122*	4.5	87*	27	6*	0.8	
0818 0200	120*	118*	4.6	85*	28.0	6*	0.6*	
0818 0416								159*
0818 0416	150*							

REF. RANGE: K
3.5
5.0
UNIT: MMOL/L
DATE TIME
0818 0416 5.4*

***** SERUM ENZYMES *****

	LD	AST	ALK P
REF. RANGE:	100	7	20
	220	40	120
UNIT:	U/L	U/L	U/L
DATE TIME			
0817 2025	254*	28	63
0818 0200	270*	32	61

***** HEMATOLOGY BLOOD COUNTS *****

	WBC	RBC	HGB	HCT	PLT CT	MCV	MCH	MCHC
REF. RANGE:	4.0	4.5	13.5	40	150.0	80	27	32
	11.0	6.0	17.5	52	400.0	100	34	36
UNIT:	K/UL	M/UL	G/DL	%	K/UL	FL	PG	G/DL
DATE TIME								
0817 2025	17.04*	3.26*	8.7*	25.8*	185	79.1*	26.7*	33.7
0818 0200	21.01*	3.15*	8.7*	24.4*	180	77.5*	27.6	35.7

(CONTINUED ON THE NEXT PAGE)

093

2-347-926-5

THE CLEVELAND CLINIC FOUNDATION
DIVISION OF PATHOLOGY AND LABORATORY MEDICINE
DEPARTMENT OF CLINICAL PATHOLOGY
8800 EUCLID AVENUE CLEVELAND, OHIO 44185
LABORATORY REPORT

PAGE 2
08/18/95
21:35

PATIENT LOCATION NUMBER NAME AGE SEX CATEGORY
051-11 2-347-926-5 GONDA, DAVID 27Y M Q
A98

PRIMARY PHYSICIAN: 00705 WIEDEMANN, HERBERT P

ADMIT DATE: 08/17/95

DISCHARGED: 08/18/95

HEMATOLOGY BLOOD COUNTS

CONTINUED MPV RDW RECHECK REVIEW

REF. RANGE: 7.3 11.7
11.1 15.0
UNIT: FL X

DATE TIME 0817 2025 9.5 14.2
0818 0200 8.7 14.0

DONE DONE

DIFFERENTIAL BLOOD COUNTS

REF. RANGE: NEUT% LYMPH% MONO%
40 22 8
70 44 7
UNIT: X X X

DATE TIME 0818 0200 92 4 4

COAGULATION

REF. RANGE: PT SEC PT INR APTT FIB CLT
8.8 .81 21.5 200
13.3 1.20 32.5 400
UNIT: SEC INR SEC MGX

DATE TIME 0817 2025 24.3
0817 2025 12.2 1.11
0817 2025 12.2 1.11 24.3 374
0818 0200 26.8
0818 0200 13.9 1.26

COAGULATION CONTINUED

DATE TIME 0817 2025 AT III: 79 X
PRO S I:

X TOTAL PRO S = 97%
(NORMAL = 70-140%)
FREE PRO S = 87%
(NORMAL = 55-130%)

NORM= 85-124

HEPCDII: 97 X

NORM= 60-160

FIBRINOLYSIS

PLS ACT
REF. RANGE: 68
122

UNIT: X
DATE TIME 0817 2025 73

094

2-347-926-5

THE CLEVELAND CLINIC FOUNDATION
DIVISION OF PATHOLOGY AND LABORATORY MEDICINE
DEPARTMENT OF CLINICAL PATHOLOGY
3300 EUCLID AVENUE CLEVELAND, OHIO 44103
LABORATORY REPORT

PAGE 3
08/18/95
21:35

PATIENT LOCATION: G51-11
NUMBER: 2-347-926-5
NAME: GONDA, DAVID
AGE: 27Y
SEX: M
CATEGORY: 0

PRIMARY PHYSICIAN: 00705 WIEDEMANN, HERBERT P

ADMIT DATE: 08/17/95

DISCHARGED: 08/18/95

***** BLOOD GASES-ARTERIAL *****

	PH	P-CO2	P-O2	BE	HCO3	CO2 CT	O2-SAT	FIO2
REF. RANGE:	7.35	34	85	-2	22	23	95	
	7.45	46	95	2	26	27	98	
UNIT:		MM HG	MM HG	MMOL/L	MMOL/L	MMOL/L	%	
DATE TIME								
0818 0416	6.95	115	65	-5	25	29	75	1.0
	/01/							

REF. RANGE: HCT
40
52
UNIT: %
DATE TIME
0818 0416 20

COMMENTS: /01/ RECHECKED 04:20 ALR

***** ARTERIAL CO-OXIMETER PANEL *****

REF. RANGE: HGB
13.5
17.5
UNIT: G/DL
DATE TIME
0818 0416 6.8

***** CALCIUM PROFILE *****

REF. RANGE: CA++
1.08
1.30
UNIT: MMOL/L
DATE TIME
0818 0416 1.21

***** BLOOD METALS *****

REF. RANGE: MG
1.6
2.4
UNIT: MG/DL
DATE TIME
0817 2025 1.5
0818 0200 1.4
0818 0416 1.4

095

2-347-926-5

THE CLEVELAND CLINIC FOUNDATION
DIVISION OF PATHOLOGY AND LABORATORY MEDICINE
DEPARTMENT OF CLINICAL PATHOLOGY
3300 EUCLID AVENUE CLEVELAND, OHIO 44106
LABORATORY REPORT

PAGE 4
08/18/95
21:35

PATIENT LOCATION

Q51-11

A90

NUMBER

2-347-926-5

NAME

GONDA, DAVID

AGE

27Y

SEX

M

CATEGORY

0

PRIMARY PHYSICIAN: 00705 WIEDEHANN, HERBERT P

ADMIT DATE: 08/17/95

DISCHARGE: 08/18/95

***** SPECIAL CHEMISTRY-BLOOD *****

REF. RANGE:

LA

0.5

2.2

UNIT:

MMOL/L

DATE TIME

0818 0416

10.6

/01/

COMMENTS:

/01/

RECHECKED 05:10 ALR

*** END OF PATIENT REPORT ***

