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

CASE NO. 96 CV 2055

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

Plaintiff

VS.

HM HEALTH SERVICES, ET AL

Defendants

DEPOSITION

OF

ROBERT D. HOFFMAN, II, M.

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

APPEARANCES

On Behalf of Plaintiff:

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On Behalf of Defendant Dr. Juan Ruiz:

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On Behalf of Defendants Dr. Alan J. Cropp and Dr. Robert DeMarco:

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OBJECTIONS AND MOTIONS:

PLAINTIFF'S EXHIBITS INTRODUCED: NONE

DEFENDANT'S EXHIBITS INTRODUCED:

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.

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

CROSS EXAMINATION:

By Mr. Travers

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

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

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

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

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

A Yes, they are.

Q Would you tell me your full name, please?

A Robert Hoffman.

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

A That's correct.

Q And you've held that position since 1992?

A That's correct.

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

A There are about 20 practicing pathologists in the department.

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

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

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

A It is.

Q As of today, I guess?

A Yes.

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

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

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

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

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

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

A Not particularly.

Q Okay.

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

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

A That's correct.

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

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

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

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

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

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

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

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

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

A No, I do not.

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

a higher degree of expertise than they may?

MR. RUF: Objection.

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

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

MR. RUF: Objection.

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

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

a No, none of them do.

Q Any of your other presentations or abstracts?

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

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

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

A Okay.

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

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

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

A No, I have not.

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

A I'm not sure I understand that question.

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

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

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

identified in your report?
A That is correct.
Q Do you have those with you today?
A I do not, no.
Q Do you have a recollection of what photographs you have viewed?
A Yes, I've seen a photograph of a cross-section of the fixed heart and a photograph of a cross-section of the unfixed heart and a photograph of a section of one of the lungs.
Q Do you still have those in your possession?
A I do, yes.
Q I assume that the book you have in front of you there, then, is not all of the materials which you have reviewed in this case?
A That is correct.
Q I'm going to ask to see what you have here in a moment, but before doing so, can you tell me what else you have looked at or reviewed not included in the materials that you have brought with you to the deposition today?
A Mr. Malik sent me a videotape of a transesophageal echocardiogram, which was of very little use to me. I can see that there's something there in the

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

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

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

Q Okay. So you have seen both?

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

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

A Yes, correct.

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

A No, I believe that the copies that I had

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

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

A That's correct.

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

A That's correct.

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

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

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

A That's correct.

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

the clinicians at the Clinic?
A That's correct.
Q Okay. Have you spoken to any of your colleagues concerning the issues presented in this case?
A Yes, I have.
Q Have you shown the slides to other members of the department here for their opinions?
A I don't believe I have, no.
Q With whom have you spoken here from the department about this case?
A I have spoken with Dr. Jacobs in the department, who trained in Africa. And with -- it's Gretta Jacobs. And also with her husband, Michael Jacobs, who is a microbiologist, both of them in the department.
Q And what was the purpose of your conversation with them?
A Asking if they had ever been exposed to cases of endomyocardial fibrosis when they were practicing in Africa.
Q Had they?
A They expressed some doubt about that as a diagnostic entity, but they had heard of it, certainly.
Q Was any information provided to you by either Dr. Jacob important in the conclusions which you have reached in this case?

A Not at all.
Q Have you spoken with any of your other colleagues?
A No, I don't think so.
Q You mentioned that you had done some review of medical literature?
A Yes.
Q Can you tell me, first of all, what you reviewed?
A Well, the usual procedure to begin a medical review is to look at the literature databases, and in this particular case I would have looked at endomyocardial fibrosis to find out what the most recent papers were on the topic, to review recent papers or recent reviews on infective endocarditis, particularly germane to mural endocarditis as we're seeing in this case.
Q This is a computerized literature search?
A Yes. The National Library of Medicine runs a very thorough, complete system called Medline, which is accessible, really, to everybody. And you can get lots of literature that way.
Q Did you make copies of any of the journal articles that were identified in your search?
A Yes.
Q Do you have those with you today?

A I do not.
Q Were any of those important in assisting you to reach the conclusions that you have authored in either of your reports?
A They were, particularly the ones on endomyocardial fibrosis. I needed a basis against which to compare the observations that I was making when I was looking at the materials from the Gonda case in order to know if this even came close to remotely resembling the diagnostic criteria that are used.
Q Do you have any recollection of what journal articles you've reviewed in that regard?
A I have several. I mean, if it becomes important, I could have those provided to you.
MR. TRAVERS: Well, I am going to ask Mr. Ruf and Mr. Malik if they would be willing to provide those journal articles that you've reviewed before your deposition today.
MR. RUF: Sure.
MR. MALIK: No problem.
Q Did you review any texts?
A There are not a lot of texts written on that subject. Mr. Malik was able to find an obscure text from India, I believe, that he had a copy sent to me. It wasn't really very helpful, didn't really add anything

above what I had learned from the journal articles.
Q Is that because of the language it was written in or the information?
A No, it was in very good English, but it just didn't add anything. I mean, it was description, and I had already seen enough description, so it came sort of late in the course of events.
Q The journal articles that you reviewed, any idea how many there were?
A There are not many. It's -- I would say a dozen, at most.
Q Were they all from a similar journal or multiple journals?
A Multiple.
Q Can you identify the journals, if not the articles?
A They're pretty obscure journals, too, most of them. It would be an exercise of extreme amount of memory.
Q I'll take that to mean you don't remember the names of the journals?
A I don't remember, I'm sorry.
Q You teach residents?
A I do.
Q Are there standard texts or journals that

you use in the training of your pathology residents?
A Yes.
Q Can you identify those for me?
A Well, I think in autopsy pathology, probably one of the best is Robbin's Pathologic Basis of Disease.
Q Do you know what the most recent publication is of Robbin's?
A Just came out this year, I believe, which I think is the eighth, maybe.
Q There was an earlier edition back at the time that Mr. Gonda's autopsy was being performed?
A Yes.
Q Do you find Robbin's to be a reliable textbook?
A Yes.
Q That's a yes?
A Yes, I'm sorry.
Q And of the various texts available to a pathology resident, would you find Robbin's to be the most authoritative of them?
MR. MALIK: Objection.
A It's a good bread-and-butter pathology textbook. There are esoteric diagnoses that are not covered, including endomyocardial fibrosis. It's not

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

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

A Yes.

Q -- information?

A Yes.

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

MR. MALIK: Objection.

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

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

A Oh, yes.

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

A Generally, yes.

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

A I believe so, yes.
Q I believe from your report you were also provided with clinical records for this patient?
A I was.
Q Have you studied all of those?
A Yes, and they are voluminous.
Q Would you identify for me what records you have, please?
A Okay. I have a copy of the autopsy report from the Cleveland Clinic. I have a copy of an admission to St. Elizabeth Hospital of 4/23/75. I have a University Hospitals of Cleveland record from 5/27/94. I have a University Health Services record from -- there's no date. Cover letter says December 6, 1995. That may just have been the day that it was mailed out, I'm sorry. Let's see. Well, no, this goes back to -- it goes as far back as 1986 through 1995, apparently.
Q I'm sorry to interrupt you. The 5/27/94 UH record, that's for an inpatient admission?
MR. FRASURE: It's University Health Services, isn't it?
MR. RUF: It's University Health Services.
Q The one before that, I thought you identified University Hospitals.

A No, this is University Hospitals admission.
Q And that is an admission?
A It appears to be, yes.
Q You have reviewed that admission?
A Uh-huh.
Q Do you know what the reason for the patient's admission was? I don't believe that that's a record that's been provided to me previously.
A It says cellulitis of face. Let's see. Then some records from Dr. Adornato in Youngstown.
Q Okay.
A Some records from Pulmonary Rehabilitation Associates; some records from Dr. Juan Ruiz.
Q That's my client.
A Okay. Some admissions from -- some records from St. Elizabeth's, 8/15/95 admission; an emergency room record apparently from St. Elizabeth's Hospital on -- I'm sorry, I don't see the date on these forms. A history and physical from St. Elizabeth's Hospital from an 8/15/95 admission; progress notes from the same admission, St. Elizabeth's Hospital; some consultations from the same admission; a report of an echocardiogram from the same admission; report of a transesophageal echocardiogram from the same admission.

Q I'm sorry to interrupt, Doctor. You've never seen tapes of any of the echocardiograms performed on him, have you?
A Yes, I have.
Q Not the TEE. Any others?
A That's the only one I believe I've seen.
Q That's the only one I'm aware of that exists. That's what I wanted to make sure.
A I have laboratory reports from the same admission, apparently. Electrocardiogram from the same admission. Some doctors orders.
Q These are all different tabs for different parts of the same admission chart?
A Yes.
Q You don't have to identify each individual section.
A Then we jump to an admission at Cleveland Clinic Foundation, 8/17/95, which is also broken down into several tabs, and which ends with an Autopsy Report and Death Certificate.
Q I suppose it's a lawyer's nature to be nosy, but in addition to the materials in the binder, there seem to be also a lot of loose documents that you've brought with you here as well.
A Yes.

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

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

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

THE WITNESS: (Complying).

MR. FRASURE: Thank you.

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

A That is correct.

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

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

when that March of '97 report was prepared?
A No. That does appear to be an error. I usually rely on the word processor to automatically enter the date, and apparently I had locked in the date in the word processor, and so it did not update automatically when I authored this. That is -- I do not know.
Q The report dated March 9 of 1997 was a report that was done after the report that is dated October of '97; do you agree with that?
A Yes, that follows. That is correct, because it clearly has information that was additional to the original report. And -- well, let me see. What was the date that I sent this to -- wait a minute. Oh, it's 3/17/98. That's the issue. Yes, the date was -- it's probably the year was in error.
Q It appears likely that the report dated March 9 of '97 was, in fact, dictated in March of '98?
A That is correct. I believe that's true.
Q You have not prepared any additional reports since that time?
A No.
Q Have you authored any earlier drafts of either of these two reports?
A I don't believe so, no. That was -- I believe you have two reports which just reflect an update

of the information based on the additional material.

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

A No, not a substantial change.

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

A No.

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

A The bottom of the page?

Q Exactly.

MR. FRASURE: Where are we, Tom?

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

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

MR. FRASURE: Probably polymicrobial?

MR. TRAVERS: Yes.

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

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

A That's true.

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

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

Q Why did you effect that change?

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

Q But they also indicated the presence of

fungal organisms, did they not?

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

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

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

Q In any event, you no longer believe that there was a fungal etiology for what you believe to be the patient's endocarditis3

A No, I don't think so.

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

A Yes.

Q One of the reasons I ask that is because

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

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

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

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

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

MR. RUF: Objection.

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

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

you and the Cleveland Clinic conclusion; correct?
A Yes, a very great difference.
Q Can you tell me how frequently in your profession substantial differences of that nature occur in the interpretation of autopsy findings?
MR. MALIK: Objection.
A They certainly occur in cases that are performed by individuals who do not have a great deal of experience, who may not have resources to investigate the findings that they're observing.
Q I don't want to interrupt you. Is your answer completed?
A It's complete.
Q Would you agree that in circumstances where you have pathologists who are well trained, with a reasonable degree of expertise and reasonable resources available to them, that it is a fairly unusual occurrence that there would be such a dramatic difference of opinion, as is evidenced in this case?
MR. MALIK: Objection.
A I would think that, given a great deal of expertise and adequate resources, it would be difficult for this degree of discrepancy to arise. Yes, I am surprised that there is this degree of discrepancy, to be honest with you.

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

MR. RUF: Objection.

MR. MALIK: Objection.

A I would not make that assumption.

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

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

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

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

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

Q And a resident as well?

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

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

MR. RUF: Objection.

MR. MALIK: Objection.

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

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

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

MR. MALIK: Objection.

MR. RUF: Objection.

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

MR. RUF: Objection.

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

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

A I believe it is an --

MR. RUF: Objection.

A It is an unreasonable opinion.

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

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

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

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

MR. MALIK: Objection.

A I disagree.

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

MR. MALIK: Continuing objection.

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

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

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

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

A No.
Q Or Mr. Ruf?
No.
Q Have your services been previously retained to serve as a consultant in medical-legal disputes?
A Yes, they have.
Q On how many occasions?
A At varying levels, maybe ten or twelve cases in the past.
Q Would they all be in the Cleveland area?
A Yes.
Q Have any of them dealt with issues concerning causes of death?
A Yes.
Q All of them?
A All of them involve autopsy findings, yes, and expert opinion related to autopsy findings.
Q Can you tell me how many of those, approximately, involved cardiac causation?
A I'd say two or three of those.
Q And was there a dispute in those cases concerning what actual type of cardiac causation occurred?
A In the other ones, no.
Q What would be the reason for your

participation, then, as an expert?
A I believe in attempting to put a time frame around a particular set of events, particularly germane to coronary artery disease, acute myocardial infarction.
Q Have any of the cases that you've been retained in previously dealt with -- I'm going to take a guess, not with endomyocardial fibrosis probably; right?
A No, this case is unique in that regard.
Q How about infective endocarditis?
A I don't believe infective endocarditis, although I do believe that one of the cases did involve nonbacterial thrombotic endocarditis.
Q Do you have a recollection of any identifying information concerning that case, for example, what lawyers were involved, what the patient's name was, anything of that nature?
A I believe it was a guy from Nurenberg, Plevin. It might be Tom Mester was the attorney that was involved. I cannot remember the name of the patient.
Q Do you recall whether you rendered a deposition in that case?
A You know, I don't specifically remember whether or not that one made it to deposition. I know that one's also settled at this point, but I don't believe I can

remember if we did a deposition or not.
Q Have these all been medical malpractice cases that you've been involved in, or is there a wider variety of cases where your expertise has been sought?
A Medical malpractice I believe they all are, yes.
Q Can you tell me how many of those cases you have rendered reports or testimony on behalf of the defendant physician or hospital?
A It's a good mix. I'd say it's almost evenly divided.
Q Do you take any actions to make it known that you might hold yourself available to act as a consultant in medical-legal matters?
A There is no reason to do that. People find you. No, I do not advertise in any way.
Q Have you ever been sued for medical malpractice?
A I have not.
Q Can you explain to me, Dr. Hoffman, your reasoning in agreeing to act as an expert consultant in this particular case? Why is it that you're doing this? What's your motivation?
A I believe that this is a very good way to 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

likely that you would do that?
A It is possible, yes. I mean, should such a case ever arise again, I think that it would have to be understood that misdiagnoses do occur.
Q Would you take some delight in being able to do that?
A No, no particular delight.
Q You mentioned your monetary compensation. How is it that you're being paid for your services in this case?
A I am providing bills to Mr. Malik, and he is providing me or has provided me with one payment up to this point.
Q Certainly you have no -- the amount that you bill or are paid is in no way dependent upon the outcome of the lawsuit?
A No, absolutely not.
Q Is it strictly an hourly fee arrangement?
A That is correct.
Q And what is your hourly fee that you are charging?
A $250 per hour for testimony, not sworn. And for this procedure here we're going for $500 an hour.
Q You don't like taking oaths? Or maybe I'm not clear on why there's such a huge distinction. Does

it depend on who's paying you?
A No, it really does not.
Q Why is it twice as expensive to give sworn testimony as unsworn testimony? I don't understand.
A I believe that it is customary among expert witnesses to make that distinction, and I believe that testimony under oath is a much more formal and much more stressful event.
Q Can you tell me how many hours you have spent so far before your deposition today in reviewing this matter and authoring your various reports?
A I believe that my account with Mr. Malik thus far has included about $1,800 worth of payments. So if you do the division there, that is all it --
Q I saw that note, though, but I thought that was prior to the time that you got the new slides and authored the addendum report.
A Right. I have not billed him since, and I would imagine that the amount of time since then may have been about $1,000, maybe, beyond that. I'm not absolutely certain.
Q Do you keep any independent records of the amount of time that you spend prior to preparing your formal invoice?
A Yes, I do.

Q Where do you have those records?
A I keep those at home.
Q Doctor, have you ever performed an autopsy on a patient with endocardial fibrosis?
A I have not.
Q Had you ever heard of that disease process prior to your involvement in this case?
A Yes, I have.
Q And what was your knowledge of that disease before the Gonda matter?
A That it is a rare entity, essentially confined to equatorial Africa and equatorial South America; that there is some question about the nature of the process, you know, the cause being relatively unknown, completely unknown.
Q You've never been involved in a case where that condition has been diagnosed?
A Absolutely not.
Q And you would claim no independent information concerning the etiology of that disease process?
A No, I have no information about that.
Q Do you know whether it's infectious in nature?
A I don't believe that anybody does,

Q What types of -- I'm going to call it EMF for endomyocardial fibrosis, if that's okay with you.
A That's fine.
Q What types of EMF are you familiar with? Are you aware of different classifications?
A I believe that it can be classified on the basis of the location of involvement in the heart. There's left-sided and right-sided endomyocardial fibrosis. There is also a spectrum of disease that ranges from that which is described in Africa to an entity which is sometimes seen in this country known as Loeffler's endocarditis.
Q Do you agree that Loeffler's is a sub-category of EMF?
A I don't believe that's necessarily true, no.
Q Can you identify any distinctions in the way that those diseases manifest themselves at end stage?
A Not at end stage, necessarily. But the classic description of Loeffler's endocarditis involves a prominent blood eosinophils.
Q I indicated I'm going to use EMF. Can I use EO's too?
A Sure.
Q What is your understanding of the

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

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

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

A I believe I have seen them, but E have not performed them.

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

A Yes

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

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

reaction.

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

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

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

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

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

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

not occurred in individuals in Africa, yes.
Q Are you aware of whether there are cases of that nature that have occurred in the United States?
A I believe I received a copy of a report from the Cleveland Clinic about that very topic.
Q So that you're aware that there have been at least two diagnosed conditions of non-African EMF here in Cleveland; correct?
A I've seen that report.
MR. RUF: Objection.
Q Do you have any reason to doubt the accuracy of that report?
A No.
Q Do you know Dr. Moody?
A No, I do not.
Q Well, is part of the reason -- well, let me ask this first. Your opinion is that this patient did not have any type of endomyocardial fibrosis; is that accurate?
A That is accurate.
Q Is that conclusion based at all on the rarity of the disease?
A Yes, it is. Common things are common. We have to work with a certain spectrum of diseases that we see in our population and only with great trepidation go

outside of that.
Q Well, that is generally true of clinicians, wouldn't you agree?
MR. RUF: Objection.
Q Let me ask the question differently. Don't you think that, in light of the rarity of that disease, that the individuals at the Cleveland Clinic would give careful consideration before authoring an Autopsy Report saying that that was the cause of this patient's death?
MR. RUF: Objection.
MR. MALIK: Objection.
A I would think so.
Q I mean, if you're going to go out on a limb and identify an extremely rare breed of disease, it's not something that a reasonable pathologist does without careful consideration?
MR. MALIK: Objection.
A I believe a pathologist has to consider very carefully the reasonableness of the diagnoses that he reaches. And one of the criteria that determines whether a disease is reasonable is whether or not it is a common disease in our population.
Q Based upon your review of the journal information, are you aware of the characteristic findings

of EMF autopsies?
A I believe so, yes.
Q Would you agree that a primary component of those is a fibrotic lesion of the heart?
A Yes, that is true.
Q Mr. Gonda had such a fibrotic lesion, did he not?
A He had a fibrotic lesion, but not one which was typical of the descriptions of endomyocardial fibrosis, either African or the ones that have been reported in the United States.
Q Doctor, I'd like to go back to the beginning of the deposition today when I was asking about whether you were just an expert or an advocate. And the reason I mention that again is because I'm not looking, hopefully, today for you to advocate your position by supplementing information to the questions that I'm asking, and I would request that you not do that.
MR. RUF: I'm going to object. He can answer the questions as he sees fit. And he's here to answer the questions. He doesn't have to answer them exactly as you want him to answer them.
Q Here's my question, Doctor. Did Mr. Gonda, on autopsy, present with a fibrotic lesion of his heart?

A Yes.
Q Are you aware of the general clinical findings on autopsy as to where fibrotic lesions are located in EMF patients?
A Yes.
Q What is your understanding of that issue?
A That they tend to involve the apices of the ventricular cavities and extend from the apices toward the base, progressively involving the AV valve mechanisms. Left tends to be more common than right.
Q Sometimes both?
A Sometimes both.
Q But Mr. Gonda's lesion was in his right ventricle; correct?
A Correct.
Q And that is one of the areas identified historically as a common site of EMF fibrotic lesions, the right ventricle?
A It is the less common of the ventricles, yes.
Q I'm not sure how I want to address this next issue with you, Dr. Hoffman, but I'm not asking what is more suggestive or less suggestive of EMF in these autopsy findings. But what I would like you to do is, from either your review of the original Cleveland record, the

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

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

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

A Suppurating lesion of the endocardial surface.

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

A They are the very nature of EMF.

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

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

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

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

Q And you are able to identify abundant leukocytes in this lesion?
A Abundant polymorphonuclear leukocytes, yes.
Q And how is it that you reached the conclusion that there were abundant leukocytes?
A To use a lay expression, they were wall to wall, whole fields filled with them in the microscope.
Q Is there anything else about the findings on autopsy or your review of the slides contradictory to the existence of endomyocardial fibrosis, other than the lung abscesses and the suppurating nature of the lesion?
A Examining the materials that I had to determine the distribution of the lesions in the heart, and here I'm speaking most specifically of the gross photographs of the heart, which I was provided, it appears that the lesion spares the apex of the right ventricle.
Q There are case studies of EMF patients where the lesion was not in the apex of the ventricle; isn't that true?
A I don't believe I can adequately answer that question.
Q Is it your testimony that the lesion must be in the apex of the ventricle in order for it to be an EMF lesion?

A No.
Q I want to ask you some questions about infective endocarditis, and I guess based upon your supplementary report, we can limit this now to bacterial endocarditis; okay?
A That's fine.
Q Just as an intellectual pursuit, if you would, if I were to present this case, the David Gonda case to you with the diagnosis of bacterial endocarditis and ask you to make a list of all of the contraindications that that would be a correct diagnosis, can you help me with such a list?
A Do you mean absolute contraindications or relative contraindications?
Q I'm going to ask you about both, and I'd be happy to allow you to answer them together or separately, at your preference.
A Okay.
Q I'm going to assume that you don't believe there are any absolute contraindications or that wouldn't be your diagnosis; right?
A Right. This case is relatively unusual, in that the inflammatory reaction does not appear to specifically involve the valves. That places it in a category of endocarditis called mural endocarditis, which

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

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

MR. RUF: Objection.

A That is not accurate.

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

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

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

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

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

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

A Yes.

Q Would you help me understand the term vegetation?

A Sure.

Q What does that mean from a medical perspective?

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

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

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

vegetations.
Q Would it be the same type of vegetations that you would normally find attached to the heart valves in patients with infective endocarditis?
A No.
Q Would it be a correct statement that there is no suggestion that the type of vegetations normally found in patients with endocarditis are evidenced in Mr. Gonda's case?
A That's, I think, a reasonable statement.
Q Would you agree that the percentage of patients who have endocarditis and experience vegetations also probably comprise more than 90 percent of endocarditis patients?
A I'm not sure I'm following that question.
Q Well, you told me before that more than 98 percent of patients with endocarditis generally have some valve involvement?
A Right.
Q Would you agree that more than 98 percent of the patients with endocarditis present with signs of vegetations?
MR. FRASURE: Anywhere or on the valve?
Q Anywhere. Anywhere in the heart.

A That's not necessarily true. I mean, are you talking present, you mean seek medical attention?
Q No, even upon autopsy if never previously -- have, I guess is what I mean. More than 98 percent of patients with infective endocarditis develop cardiac vegetations?
A Yes.
Q And that is something that, if it is evident upon autopsy, you would certainly expect to be identified in the Autopsy Report?
A Yes.
Q And, again, there's none in Mr. Gonda's case?
A That's correct.
Q Have you ever personally done an autopsy on a patient with endocarditis that did not have valvular involvement?
A Yes.
Q That was a mural?
A Yes.
Q In regard to the mural type of endocarditis, you indicated that there's two sub-categories there, one where it is overlying a diseased myocardium. Do we have any reason to believe that that was present in Mr. Gonda's case?

A Not specifically, no.
Q Well, do you have an opinion as to which of the two types of mural endocarditis he experienced?
A I believe that he may be having -- it's more likely that he's having embolism of infected material to the heart and lungs.
Q This is, perhaps, just an aside, but of some significance to my client, Doctor. When a patient with endocarditis develops vegetations on his heart valves, is that something that normally an examining clinician can pick up by auscultation?
A I believe that changing heart murmurs are observed in patients with endocarditis, yes, with valve involvement.
Q So if you listen to the patient's heart and hear no signs of any changing heart murmurs, you would agree that if that patient had endocarditis, he would be in the two percent of those patients or less who have no valvular involvement?
A Well, first of all, I do not listen to hearts. But without involvement of the valves, the mechanism for the unusual sounds would seem to be absent.
Q Because what clinicians are looking for when they listen to the heart valves are signs of developing vegetation?

MR. RUF: Objection.

MR. MALIK: Objection.

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

A I'm sorry?

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

A That is often the case, yes.

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

A Yes.

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

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

than others.
Q But there are multiple pathogens in those results, are there not?
A Yes. Multiple pathogens is actually a type of infection. If an infection spreads from the gastrointestinal tract, most often or very often it can be polymicrobial, often involving anaerobic organisms, as was seen here.
Q Well, do you hold an opinion as to which of those pathogens identified in your report were the cause of what you believe to be endocarditis?
A I believe in this case the organism that was identified as belonging to the Bacteroides fragilis group is of particular concern.
Q Is that the enterococcus?
A No, the Bacteroides.
Q How many different types of bacteria did you identify in your stain slides?
A The stain is not a very reliable way to speciate bacteria. I saw both gram positive and gram negative organisms on the slide that I examined.
Q But at least three different species of gram positive, did you not?
A No, you're looking at the results in culture, and you cannot --

Q You're right. You're right. I apologize. The culture is a reliable source of identifying the existence of pathogens, though, is it not?
A It certainly provides a more definitive identification of an organism than one could ever achieve using staining alone.
Q Well, let's set aside that report for a moment and concentrate just on your slides. How many species of gram positive bacilli did you identify?
A I cannot identify their species based on the stain. I can just say that it's a gram positive rod.
Q Okay. You say both gram positive and gram negative?
A Rods, correct.
Q But there's nothing on -- I'm not trying to be tricky here. I understand that you cannot identify the species from the slides. But for that reason, then, there's nothing on the slides that would dispute the existence of at least three different species of gram positive bacilli identified on the Path Report; would that be accurate?
A I think that's accurate, yes.
Q And wouldn't you agree that these are all additional indications that if this patient had endocarditis, he was in an extremely minute type of that

disease process?
A These are not usual pathogens seen in endocarditis, if that's what you're driving at.
Q What are the most frequent pathogens causing bacterial endocarditis?
A Staph, Strep, in fact, organisms usually not considered to be pathogens. The Strep viridans group can get a foothold on a heart valve and create an infective lesion. Gram negatives, much more rarely. I think that's the -- probably described 95 percent of them right there.
Q Neither the pathology report nor your slide review identifies either Staph or Strep pathogens; correct?
A That's correct.
Q If I could bring you back just a little bit, Dr. Hoffman, in my own mind, at least, I'm still going on the issue of reasons that put into question a diagnosis of endocarditis. And would you agree that the lack of Staph and Strep bacterium would decrease the credence of endocarditis as the correct diagnosis?
A No.
Q In a patient with infective endocarditis on autopsy, would you expect to be able to identify certain expected findings in other organs?
MR. FRASURE: Can you repeat that,

read that back, please?
Q I don't think it was well phrased. Let me just try again. In a patient with infective endocarditis, upon autopsy, are there certain expected findings in organs other than the heart?
A Yes.
Q Can you identify what some of those are?
A Embolism from the involved chamber to the next vascular bed. So in right-sided endocarditis, lung abscess is found very commonly, as seen in this case. In left-sided endocarditis, essentially any vascular bed in the body, brain involved, kidney involved, any tissue can receive a septic embolus in infective endocarditis on the left side.
Q This patient had no evidence of infarct to any organ, did he?
A I believe the Autopsy Report describes lung infarct.
Q You're right. I apologize. There are no other organs, other than the lung, where infarct is identified in Mr. Gonda's autopsy; correct?
A I believe that's correct.
Q And none of the slides that you've reviewed prompt you to disagree with the conclusion on lack of infarct?

A I don't believe there are infarcts outside of the lung, based on what I have seen.
Q Did you review that portion of the Autopsy Report concerning what he calls or she calls the external examination?
A I believe I did at one point, yes.
Q Let me ask first, isn't it generally true that patients with infective endocarditis will present with signs of that disease that are observable by an external examination?
A Not necessarily, and specifically not necessarily in a case of right-sided endocarditis.
Q Well, I was hopeful that I didn't pose my question by way of necessarily, but isn't it generally true that there is evidence of the existence of a patient's endocarditis upon external examination?
A Only in left-sided endocarditis.
Q We've been at this a while, Doctor. If I've asked you this already, I apologize. I don't think I did. Can you estimate for me the percentages of patients with endocarditis of the left side, as opposed to the right side?
A Cases of right-sided endocarditis that I've seen in the autopsies that I've performed have been largely confined to individuals that had infected central

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

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

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

MR. TRAVERS: Correct.

A Right-sided, oh, maybe five percent.

Q Or less?

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

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

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

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

MR. MALIK: Objection.

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

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

MR. MALIK: Objection.

A To be honest with you, the majority of

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

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

MR. RUF: Objection.

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

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

A Yes, that's correct.

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

A Yes. Oh, absolutely.

Q Can you identify what those are?

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

Q Certainly patients with artificial valves?

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

Q IV drug use can be a predisposing factor?

A We've already discussed that, yes.

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

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

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

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

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

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

A Absolutely not.

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

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

Q Are you aware of the nature of the

antibiotic therapy that he received?

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

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

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

Q You used the term in your report acute endocarditis.

A Yes.

Q That is opposed to subacute, I assume?

A Yes.

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

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

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

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

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

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

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

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

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

there?

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

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

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

Q Would you agree that that vasculitis of

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

MR. MALIK: Objection.

A That would be reasonable, yes.

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

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

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

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

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

with you?

A That's fine with me.

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

THE WITNESS: Oh, I can continue.

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

(Whereupon a brief recess was taken.)

CROSS EXAMINATION:

By Mr. Frasure

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

A I think that's reasonable, yes.

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

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

Q I notice you are Board Certified in anatomical pathology?

A Correct.

Q Are you Board Certified in clinical

pathology?
A I am not.
Q You are not?
A I am not.
Q Are some of your colleagues here Board Certified in clinical pathology?
A Yes, I believe so.
Q Have you taken that exam?
A Never have.
Q So what I understand here is you believe the patient had a mural endocarditis; correct --
A That's correct.
Q -- on the right side, and polymicrobial in nature?
A That's correct.
Q And caused by bugs that are not normally causing that type of endocarditis; is that correct?
A That's correct.
Q So we've got an unusual part -- well, first of all, *you* said mural is unusual?
A Right.
Q Within mural, is right-sided less likely than left-sided?
A Mural endocarditis of the right side includes a lot of lesions that are brought in with foreign

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

Q Do you think that's what happened here?

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

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

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

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

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

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

A Yes, that is true.

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

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

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

he was debilitated?
A Until the terminal events, yes.
Q So this disease, the mural endocarditis, when it's found, it's normally not found in the age group and the health situation of this gentleman; correct?
A Correct. The reported cases, I believe, are not this sort of scenario.
Q Are there certain risk factors for the mural that we need to cover, or would those fall within the same risk factors or predisposing factors that you were asked about for bacterial in general?
A Well, you mentioned the immunosuppressed patient. I believe that most of the reported cases of mural endocarditis that have been reported are in cancer patients on chemotherapy and are usually fungal infections of the wall.
Q Is mural endocarditis normally a fungal infection?
A I'm not sure I know how to answer that question. It's such an unusual disease, to say normally is, you know -- when you have an infective lesion adhering to the wall, it's whatever the infection is that you can demonstrate.
Q I guess if you take all mural endocarditis patients, will most of them have a bacteria

causing it or a fungus causing it?
A I don't believe I know the answer to that question. I mean, I told you that the one paper which I believe was written by a fellow named Roberts about mural endocarditis who described some patients at the National Cancer Institute, all of those were NCI patients. I mean, they were all on protocol for some terminal malignancy, and they -- I believe nearly all of them had fungal endocarditis, but that is not --
Q You mentioned earlier the -- before I get to that, where do you think the infection started here in the body, Doctor?
A That is hard to know, because symptom-wise, he seems to have been complaining of things in his head and neck. But, unfortunately, the head and neck are things that are not autopsied, and we may never know for sure.
Q I take it you can't say to a reasonable medical probability where it started; is that correct?
A I believe to a reasonable medical probability it was somewhere in the head and neck, because he had an autopsy that appears to have addressed most of his internal organs and came up with nothing in particular. There are no complaints in the arms and legs and joints that we could point to, so it's vague and I believe

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

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

A Yes.

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

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

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

A Yes.

Q In your medical training, had you studiec endomyocardial fibrosis?

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

Q So when you talked to two of your

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

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

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

A That's correct.

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

A I'll repeat it.

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

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

Q I got that.

A Well, that's the most important.

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

A Yes.

Q Did this, in your opinion, involve the apex?
A No.
Q That's why I was confused. I took it from the autopsy that it had some involvement.
A No. From the photographs and also from the autopsy description, this lesion is described as lying in the ventricular outflow tract, which is a basal structure.
Q Page 4 of the autopsy, where it starts, in the right ventricle --
A I'm sorry, I'm not with you yet.
Q About halfway down on the page.
A Okay, here we go.
Q Says, in the right ventricle there is a soft, friable, white-colored mass which extends from the apex of the ventricle to within .5 centimeters of the pulmonary valve. Do you take that to mean that there is involvement with the apex?
A Not necessarily.
Q Why?
A Very often, actually, virtually always, in autopsy, there will be clotted blood in the chamber of the right ventricle. And, you know, one of the important things that an experienced pathologist develops is an

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

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

A That's correct.

Q How many photographs were there, do you recall?

A Of the heart, two.

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

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

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

MR. TRAVERS: No. Doctor --

MR. FRASURE: Doctor, Mark Frasure. I think I was saying Doctor, comma, I'm Mark Frasure.

A I didn't think you were a doctor.

Q You could tell; right? You had two

photos of the heart?
A Correct.
Q Would you expect to see the finding on the gross exam that is in the Autopsy Report about there being a soft, friable mass which extends from the apex, would you expect to see that finding on a case involving bacterial endocarditis, that gross description that I just read there?
A I wouldn't expect it, no. I would expect to see valvular lesions, is what I would expect to see.
Q So that description I read, you're saying, then, that that is inconsistent with the photographs?
A Yes.
Q Okay. Can the autopsy pathologist see certain things that are not contained within the photographs?
A Yes. An inexperienced person can do a tremendous amount of damage to vegetations and such. They're very fragile, and, you know, if they got torn off before the photograph, I suppose that we might not see them.
Q Let me ask you, what is it about the Cleveland Clinic pathology that you think was so unreasonable? Was it what they didn't examine, or was it their conclusions, or did they examine the right things,

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

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

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

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

Q Septic embolism?

A Yes.

Q Those are red-flag conditions for bacterial endocarditis?

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

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

A Yes, I just told you there were two

photographs of the heart.
Q The lungs, I'm sorry.
A Yes, there was at least one photograph of the lung, I believe one.
Q Do you find any of these things that you mentioned, abscesses, vasculitis, septic embolism on photos of the lung?
A It's not possible to identify them as such, necessarily, on the photographs. But in the context of the microscopic slides, it's very clear that that's what they are.
Q And can you point to me in the Autopsy Report where you believe this is grossly understated so I'm clear I understand what you mean?
A Well, in the final diagnoses, they talk about multiple thromboemboli to both lungs. Now, reading that report --
Q What page are you on?
A I'm on the front sheet, Page 1.
Q Okay.
A That implies to the reader that these are sort of garden-variety thromboemboli, bland thromboemboli as might arise in the leg veins of an old lady, break loose, and be found in the lung. This is not the picture of septic thromboembolism that we're seeing here, and

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

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

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

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

Q Your findings on slides?

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

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

A Yes.

Q -- you're saying?
A Much more serious.
Q And if that's true, does that point away or toward or have no effect on whether it's a fibrosis or an endocarditis?
A I think it makes it less likely that it's endomyocardial fibrosis.
Q And more likely that it's endocarditis?
A Yes.
Q Why?
A Because in endomyocardial fibrosis, you would not expect to see this rip-roaring, acute inflammatory process going on.
Q That would involve the lungs?
A The lungs or the heart.
Q And in mural endocarditis, is this kind of, as you say, rip-roaring process going on? Is that typical in mural endocarditis?
A Yes.
Q Is the definition of mural endocarditis that it does not involve valves?
A Not specifically. It's that it does involve the wall of the chamber.
Q So some mural endocarditis does involve the valves?

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

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

A That seems reasonable, yes.

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

A Yes.

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

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

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

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

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

A That is my impression.

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

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

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

A I really cannot comment on that.

Q Let me ask you this.

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

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

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

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

phone call, perhaps a letter.

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

A Yes.

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

Clinic here?
A Not yet. Understanding that this case is in litigation, I thought it was most prudent not to raise that issue.
Q But the Cleveland Clinic --
A I believe that they will be made aware of this process.
Q So that's the reason you haven't told anyone at the Clinic, is because the case is in litigation?
A That is my assumption.
Q You learned in, what, late '97 that your opinion -- you developed your opinion that this was not fibrosis in the October range of '97?
A That's right, yes.
Q Is endocardial fibrosis the same as endomyocardial fibrosis? I've seen it called two different things.
A I believe that the disease that is described in Africa is uniformly described as endomyocardial fibrosis. That is a disease entity. Endocardial fibrosis could just be a description. It's hard to know.
Q Mr. Travers asked you about two sub-categories of mural endocarditis, and I want to see if I have these correctly. One is overlying a disease of the

myocardium, and you believe that was not present here?
A I believe that's right, yes.
Q And the other sub-category is an embolism of infected material going to the heart and lungs?
A Yes.
Q And you believe that's probably what was present here?
A Probably.
Q Okay. Do you think this was an anaerobic infection that came from the head and neck?
A Well, I mean, the organisms that we have to look at and the polymicrobial nature suggest anaerobic infection, yes.
Q Of all the infections that develop in the head and neck, are anaerobic less common than the nonanaerobic, if that makes sense?
A Well, I'm not certain what the answer would be.
Q Is that outside your area of expertise?
A I believe that's outside my area of expertise.
Q More in the area of infectious disease?
A Right.
Q Did you find some organisms here in the lung that were not, apparently, found in the heart? I'm

unclear on that.

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

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

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

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

A That's correct.

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

A Yes.

Q Could you explain that to me, please?

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

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

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

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

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

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

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

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

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

A Correct.

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

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

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

A Yes.

Q Found in the lung or the heart?
A In the lung. The cultures, apparently, were taken from the lung, and those are the only cultures I know of in this case.
Q Okay. What's your explanation for why these would not have grown from the heart?
A Because they were never sampled, apparently.
Q So you're saying apparently never any cultures from the heart?
A That is the impression I gained from reading the report.
Q And if that's true, is that suboptimal technique, in your opinion?
A Well, in trying to be fair to the people who were performing this case, who were probably relatively inexperienced, they may not have thought this looked like endocarditis, and therefore said we don't have to culture it. I think anytime -- I tell my residents if they find a lesion that looks like an abscess or an infected focus, even though it's well into the autopsy, after they've taken their routine surveillance cultures, that they should probably get a sample of it up to microbiology simply just to cover their tail, if you will.
Q Okay. Do you know if there's often a

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

A I believe it can occur, yes.

Q And was a thrombus present here?

A There is thrombus present, yes.

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

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

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

A I believe it was on the second round.

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

A Yes.

Q Does the passage of two years affect the

reliability at all of your gram stains?
A I don't believe so, no. The tissue has been embedded in wax all that time, so there's really no contact with air. They were cut freshly.
Q You found gram negative bacilli in your stains?
A Yes.
Q How many types of bacteria qualify as gram negative?
A That's a long ist.
Q Can you be sure the bacteria you found were the same as in the lung?
A No, not certain, but I believe that's reasonable to tie the case together. It's the same heart and the same lung.
Q Are there many different types of gram positive bacilli?
A Yes.
Q Can you be sure the gram positive bacteria you found were the same as in the lung?
A The same answer again.
Q Why weren't the other organisms that were seen in the lung culture, why were they not found in your stains of the heart?
A 1 do not know.

Q Can this be because of contamination?
A That is a possibility.
Q If that's true, then would we have some organisms found in the lung were contaminated and some were not due to the contamination?
A I suppose that has to be possible, again, reiterating that I do not know anything about the specific procedures that were used in performing the autopsy, only assuming they are reasonable procedures.
Q You mentioned the finding of severe acute necrotizing arteritis in the pulmonary arteries. What time frame are you talking about do you believe that was present?
A I don't think more than several days.
Q Speaking of more than several days before the death?
A Yes, before the death.
Q Just so I'm clear here, you've described what you found at autopsy, what you found that you believe was present at autopsy?
A Yes.
Q Are you using any of the events of Mr. Gonda's life and his medical care and his presentation to support your diagnosis, or are you basically just going on what's found at autopsy? In other words, are you trying to

correlate the clinical and the anatomical or just the anatomical?

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

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

A I wouldn't speculate.

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

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

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

MR. RUF: Objection.

Q Have you ever heard of that?

A I suppose it is possible.

MR. FRASURE: Okay. Let me pass to

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

CROSS EXAMINATION:

By Mr. Blomstrom

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

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

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

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

Q All right.

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

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

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

I've tried to make this my report.
Q Are you certain that you don't?
A No, I'm not, actually.
Q If you have them, where would they be?
A I presume in my office.
Q Do you have a portion of records concerning this case in your office?
A Yes.
Q What do you have in your office that you haven't brought with you today?
A I have a transesophageal echocardiogram tape. I have glass slides that were provided to me from the Cleveland Clinic that were stained there. I have some unstained slides. I have the stains that we performed here on some of those. I have some library research. I have some -- what else? I believe I have some computer disks that have the -- you know, these reports on them. I think that's the substance of what I have.
Q Is that all of what you have?
A I think that's everything, yeah. Is there some specific thing that I'm --
Q No, I'm just being --
A You're being an attorney, okay.
Q No, I'm not being an attorney, I'm just -- as an old English major, I am trying to be aware of

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

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

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

A The natural course?

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

A Untreated, you mean?

Q Yes.

A I believe it would have resulted in death.

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

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

Q All right.
A However, knowing my diagnosis of the final outcome, I would have expected that he would have had a chronic febrile illness that terminally would have ended in a respiratory symptom complex, that dyspnea would figure very prominently, and that respiratory hemorrhage would be a very important component of the terminal course.
Q I gathered from your testimony earlier that, as far as the initial cause of his problem is concerned, you would expect that he would have had a febrile course from that before he developed the endocarditis; correct?
A Yes.
Q So the fact that he has a fever or not is not necessarily an indication of the onset of endocarditis; correct?
A I suppose that's true, yes.
Q And to your belief, you think that he probably had a cause that was infective arising in the head and neck; correct?
A That's where his complaints were.
Q What type of illness or pathological process would you expect for him to have in those areas that could give rise to a polymicrobial endocarditis?
A A pharyngitis, you know. I don't think

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

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

A Okay.

Q May I see them, please?

A Certainly.

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

(Whereupon Defendant's Exhibit A was marked.)

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

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

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

respiratory system, just so that I understand; correct?
A They are reporting a mass in the left ventricular outflow tract, which I do not dispute. I see something that I would presume would be interpreted as a mass. And they are seeing white, friable material in the pulmonary vasculature, which I presume the gross findings in the condition that I have described would look something like white, friable material. I mean, they don't have microscopic resolution, as they would have in examining the slides. I have no problem with what they think they've seen grossly. I just think they've misinterpreted it.
Q Well, earlier I think you told us -- if you didn't, please tell me that I'm wrong -- that your findings on the slides do not match what you are seeing in the gross description on the report. And now you're saying that they're consistent. So how is it that they cannot match but be consistent?
A The findings that I see on the slides I diagnose as -- I am coming up with diagnoses, can I understand that that may be what they thought they saw, yes. So in that way, I suppose it is consistent.
Q Well, then, what did you mean when you earlier said that your findings on the slides do not match what you were seeing on the gross description?
A Perhaps I was taken out of context, but

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

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

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

A Yes.

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

A Okay.

Q How much of that represents the inflammatory process?

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

Q Where, with respect to the inflammatory process, is the fibrosis that you found or that was found?
A Underneath it. It is deep, away from the lumen of the right ventricle.
Q So that entire mass here is inflammatory process, and the fibrosis is really within the heart wall; correct?
A Right.
Q With respect to the inflammatory mass, then, is that the same thing that you said is the luminal face that was very fresh?
A Yes.
Q And you may have said how long that was there. Is that what you were referring to being there as a matter of days?
A Yes.
Q And by a matter of days, you don't mean so much as a week; right?
A That's -- yes. I mean, I say days so as not to say weeks or months or minutes or hours.
Q But just so that we're not clear -- just so that we get clear, okay -- I don't think we're clear yet, but I want to get clear -- you're not saying that the length of time that that inflammatory process was there exceeded seven days, are you?

A The part of the process that we perceive as scarring, endocarditis, you know, on the surface of it, has to have been there for at least several weeks. Scarring takes time to develop.
Q That's the part that's within the wall?
A That's the deep part.
Q Correct?
A The more superficial parts of it are apparently much fresher, and, again, it's a gradient. There are different stages of a process going on, the most recent of which appears to be very, very fresh.
Q Thank you for your statement, but let's try one more time. Is it true that this inflammatory mass which you said accounts for the 3.5 by 1.5 by .3 centimete mass, was there less than a week prior to death?
A That part of it, yes.
Q Now, you said that the underlying fibrosis within the wall or the scarring would have been there several weeks, in your view; correct?
A Yes.
Q So let's go through the same exercise fo several weeks.
A Okay.
Q Not the exercise, but the term.
A Okay.

Q How long is several weeks, in your estimation? I want to get an outside estimation as to how long you're saying that was there.
A Outside?
Q Outside.
A The oldest part of that may have been from birth. I mean, there is no upper end.
Q That certainly covers it, but --
A Scarring is sort of an end stage, and once it gets to a certain point, you just can't tell.
Q How much scarring was there, then, do you have a measurement? Do you have another way of quantifying it for us at the time of the autopsy?
A I did not have the benefit of being able to measure it in the gross, and I would have to have the slides in front of me in order to do it based on the microscopy, with a whole lot of caveats based on shrinkage of the tissue and sampling and other things. The gross is really the best way to have that measurement. I don't believe, based on my recollection, that it involved the entire thickness of the wall.
Q On, I think, the 16th or the 17th of August, there was a 2-D echo followed by a TEE done concerning this young man's heart. And that TEE refers to a prominent mobile right ventricular mass. Do you recall

seeing that?
A I recall seeing that, yes.
Q All right. Now, this prominent right ventricular mass, was that the inflammatory response?
A It might be the inflammatory response. It may be blood clot adherent to that.
Q So the inflammatory response may have a blood clot adherent to it?
A Yes.
Q And that inflammatory response would have to be there before the blood clot could be adherent to it; right?
A Reasonably, yes.
Q I'm very close to the end, if you'll bear with me just a minute.
A Certainly.
Q With respect to the actual immediate cause of death, if I understand you correctly -- and please correct me if I'm wrong -- the pulmonary vasculitis that existed led to an erosion, if you will, of the wall of the artery, which led to the bleeding that caused his death; is that right?
A That's correct.
Q You referred to the lung abscesses as septic thromboembolism. How did you come to the conclusion

that the thromboemboli were septic in themselves?
A An extension of the extreme amount of inflammation. Thromboemboli in the lung, garden variety, things we see all the time in little old ladies that suddenly die, do not have nearly this degree of inflammation, and the inflammation certainly does not go eroding through the wall of the blood vessel. This is a red flag.
Q The word septic is an inference from what you did see; right?
A Yes.
Q You referred to some slides as being hot, but you didn't indicate which slides. Which slides were hot?
A I used the term hot to describe --
Q I know how you used the term hot. Which ones?
A Not to imply that they have been obtained by illicit means. I've got all these attorneys here. The acute inflammation, as I've described it, I would describe as hot. So the slides that I have indicated on my report, 11 through 16, inclusive --
Q Okay.
A -- 7 and 10, at least those. I'm not certain I can say about the others.

MR. BLOMSTROM: Thank you.

THE WITNESS: You're welcome.

RECROSS EXAMINATION:

By Mr. Travers

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

A I believe that's true, yes.

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

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

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

A I don't think it was.

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

A That is correct.

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

MR. FRASURE: Nothing further.

REPORTER'S CERTIFICATE

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

Debra M. Moore

Debra M. Moore
Registered Merit Reporter

STATE OF OHIO)
) SS: CERTIFICATE
COUNTY)

I, ROBERT D. HOFFMAN, II, M.D., depose and say that 1 have read the foregoing deposition and find it true and correct, unless otherwise specifically excepted to and indicated on Page 115-A, and any following numbered pages thereafter, if applicable, and I subscribe my signature to the aforesaid deposition this _____ Day of January, ~~1998.~~ 1999 RDH

ROBERT D. HOFFMAN, II, M.D.

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

SWORN AND SUBSCRIBED before me this 4th Day of January, ~~1998.~~ 1999

Notary Public
My Commission Expires 10-07-02 DM

S

Y

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 AUTOPSY PATHOLOGY - (WORD OMITTED)
82	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

MD PhD
Signature of Deponent

DAVID B. MALIK CO., L.P.A.
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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!

DEFENDANT'S EXHIBIT A

NEW AUTOPSY INFORMATION SHEET (REQUISTION)

Post Mortem Microbiology
CLEVELAND CLINIC

AUTOPSY NO: A95-169 DATE OF AUTOPSY: 8/18/95

NAME OF DECEASED: David Gonda PROSECTOR: Nancy Wang

CLINIC NO: 2347 9265 CLINICAL PATHOLOGY RESIDENT: Dave Oh

****

Age: 27 Clinical Summary: massive hemoptysis

ANATOMICAL FINDINGS: (R) ventricular tumor

****

Date cultures received in microbiology: ______

Type of Specimen	Specific Test Requested
A. Lung	A. bacteria fungi
B.	B. └ aerobic anaerobic
C.	C.
D.	D.
E.	E.

****

Microbiology Findings:	Specimen:	Final Report:	Resident Notified
Bacteriology: ~~Rare Enterococcus sp (1)~~ ~~Rare Enterobacter sp (2)~~ Rare Yeast sp. ~~Lactobacillus~~ in thio only		Anaerobic NSF Bacteroides fragilis (→ NON-SPORE FORMING) YPR 8-22-95	Date 8/1 Initial Km
Mycology ~~THIOGLYCOLLATE BROTH~~ No other Fungus Found Few Saccharomyces cerevisiae			Date 9-15-95 Initial
AFB			Date Initial
Virology			Date Initial
Other			Date Initial

Date Reported to Anatomic Pathology 11/29/95 Signed Florence Elgar

VJC 2-347-926-5

THE CLEVELAND CLINIC FOUNDATION
DIVISION OF PATHOLOGY AND LABORATORY MEDICINE
DEPARTMENT OF CLINICAL PATHOLOGY
9500 EUCLID AVENUE CLEVELAND, OHIO 44106
LABORATORY REPORT

PAGE 1
08/18/95
21:35

PATIENT LOCATION	NUMBER	NAME	AGE	SEX	CATEGORY
G51-11 A98	2-347-926-5	GONDA, DAVID	27Y	M	O

PRIMARY PHYSICIAN: 00705 NIEDENAHN,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	3.8	0
	8.4	5.8	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*	3.8*	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	NA
REF.RANGE:	65	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	128*	118*	4.6	85*	28.0	6*	0.6*	
0818 0416								159*
0818 0416	150*							

	K
REF.RANGE:	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	17.84*	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

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LABORATORY REPORT

PATIENT LOCATION	NUMBER	NAME	AGE	SEX	CATEGORY
GS1-11 A90	2-347-926-5	GONDA, DAVID	27Y	M	Q

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	%		
DATE TIME				
0817 2025	9.5	14.2		
0818 0200	8.7	14.0	DONE	DONE

DIFFERENTIAL BLOOD COUNTS

	NEUT%	LYMPH%	MONO%
REF.RANGE:	40	22	0
	70	44	7
UNIT:	%	%	%
DATE TIME			
0818 0200	92*	4*	4

COAGULATION

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

PRO S I: % TOTAL PRO S = 97%
(NORMAL = 70-140%)
FREE PRO S = 87%
(NORMAL = 55-130%)
NORM= 85-124

HEPCOII: 97 % NORM= 60-160

FIBRINOLYSIS

	PLS ACT
REF.RANGE:	68
	122
UNIT:	%
DATE TIME	
0817 2025	73

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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* /01/	115*	65*	-5*	25	29*	75*	1.0

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

COMMENTS: /01/ RECHECKED 04:20 ALR

ARTERIAL CO-OXIMETER PANEL

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

CALCIUM PROFILE

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

BLOOD METALS

	MG
REF.RANGE:	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

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PAGE 4
08/18/95
21:35

PATIENT LOCATION	NUMBER	NAME	AGE	SEX	CATEGORY
GS1-11 A90	2-347-926-5	GONDA, DAVID	27Y	M	O

PRIMARY PHYSICIAN: 00705 WIEDEMANN,HERBERT P

ADMIT DATE: 08/17/95 DISCHARGE: 08/18/95

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

	LA
REF.RANGE:	0.5 2.2
UNIT:	MMOL/L
DATE TIME	
0818 0416	10.6* /01/

COMMENTS: /01/ RECHECKED 05:10 ALR

*** END OF PATIENT REPORT ***