IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

MARCIA GOLDEN, et al., — CIVIL DIVISION

Plaintiffs,

vs. — Case No. 144, 221

MARK R. LEVINE, M.D., et al.

Defendants. — DEPOSITION TRANSCRIPT OF: Peter J. Jannetta, M.D.

DEPOSITION DATE:
September 7, 1989

PARTY TAKING DEPOSITION:
Defendant, Dr. Levine

COUNSEL OF RECORD
FOR THIS PARTY:
Anthony P. Dapore, Esq.
Jacobson, Maynard,
Tuschman & Kabur
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REPORTED BY:
Susan Perkins, RPR
Notary Public

VIDEO TAPE DEPOSITION OF PETER J. JANNETTA, M.D., a witness, called by the Defendant for examination, taken by and before Susan Perkins, a Registered Professional Reporter and Notary Public in and €or the Commonwealth of Pennsylvania, at the law offices of Doctor Jannetta, Oakland, Pennsylvania, on Septamber 7, 1989, commencing at 10:20 a.m.

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APPEARANCES:

FOR THE PLAINTIFFS:
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* I N D E X *

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PETER JANNETTA, M.D.,

having been duly sworn,

was examined and testified as follows:

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DIRECT EXAMINATION

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BY MR. DAPORE:

Q Good morning, Doctor Jannetta.

A Mr. Dapore.

Q Would you state your full name for the record, please?

A Yes, sir. I'm Peter Joseph Jannetta.

Q And what is your profession?

A I'm a neurosurgeon.

Q And what is your business address?

A Scaiffe Hall, Room 408. Scaiffe Hall is the University of Pittsburgh School of Medicine's major building.

Q And you indicated that you're a neurosurgeon. What is the specialty of neurosurgery?

A Neurosurgery is that branch of surgery that encompasses surgery of the brain, the tissues surrounding the brain, the spinal cord, the nerve roots coming out of the spinal cord and, of

course, the brain, the nerves coming out of the brain and the nerves coming to and from the torso and extremities.

Q Would you briefly run us through your education and training beginning with your undergraduate degree, the degree you received, the year of your receiving the degree on through your post-graduate training?

A Yes, sir. I graduated from the University of Pennsylvania with a B.S. in zoology in 1953, from the University of Pennsylvania School of Medicine with an M.D. in 1957. I interned for one year at the Hospital of the University of Pennsylvania.

I then became assistant resident in surgery and then chief resident in surgery -- this is general surgery -- at the Hospital of University of Pennsylvania until 1963, June of '63. During that time, I was an instructor in pharmacology. And I spent 15 months fulltime and about two-and-a-half years part-time working in a neurophysiology laboratory, which was part of my planned program. I had an NIH special fellowship in neurosurgery giving me background in general surgery and in the laboratory.

When I completed the general surgical residency, I went to UCLA, University of California Los Angelos, where I was assistant resident and then chief resident in neurosurgery from July of '63 through December of 1966. And actually there was an overlap in -- on December 1st of 1966, I became associate professor and chief of the division of neurosurgery at Louisiana State University School of Medicine in New Orleans, and I actually started working in January of '67.

I became professor of neurosurgery there in 1971, but that same year I came to Pittsburgh as chairman of the then division of neurological surgery in the med school here and professor. And in October of '73, we achieved departmental status. I've been here ever since.

Q You mentioned a subject in your training of neurophysiology.

A Yes, sir.

Q What is that?

A That's the study of how nervous tissue functions, normally and abnormally.

Q And you spent 15 months fulltime and

two-and-a-half years part-time in that area?

A Yes, sir.

Q What hospitals do you currently hold privileges at?

A At Presbyterian University Hopsital where I do my major work, at Children's Hospital of Pittsburgh, at the Montefiore Hospital of Pittsburgh, at the Veteran's Administration Hospital, which is just up the hill here. I have consulting privileges at West Penn Hospital. And I have privileges at St. Margaret's, but I never go there very much.

Q Are you involved in teaching?

A Yes, sir.

Q And what does that involve?

A Well, primarily my teaching is informal to medical students and occasional large full class lectures but lots of teaching at conferences to medical students, residents, a lot of teaching rounds, operating room, conferences, teaching with my colleagues, and then national, regional, local and international conferences where I do a lot of talking.

Q In fact, during the course of this trial in late October, you will just be returning from an

international speaking engagement?

A That's correct, in Japan, India and Germany.

Q Within which states are you licensed to practice medicine?

A I'm licensed in Pennsylvania, California and Louisiana.

Q Have you made any contributions to the medical literature?

A Yes, sir.

Q Can you give us an estimate as to the number of articles you've written either for journals or chapters in books or books themselves?

A 40 plus chapters -- I think it's probably 50 by now; 135 or more refereed articles; a number of the letters to the editor; co-authored one book. I have another book which I've co-edited coming out in the fall and a book which I've written coming out next spring. I was hoping to have it out next fall but -- this coming fall, but it won't be ready.

Q And are those books and chapters and articles dealing with neurosurgical subject matter?

A No, they're not. The earlier ones were general surgical.

Q Have you had any contributions in the medical literature dealing with the trigeminal nerve?

A Yes, sir, many.

Q And can you give us an approximation as to the numbers of articles or chapters in textbooks?

A If I include chapters and articles probably 75 or more. It may be a few less. It may be a few more.

Q At this time, do you devote more than 75 percent of your professional time to the active clinical practice of neurosurgery?

A I have a lot of administrative work to do, and I have a very active practice. On the base of a 40-hour week, I would say yes. But on the kind of week that I work, I would say no.

Q In terms of adding into that your teaching responsibilities, would you say that your teaching responsibilities and your clinical practice exceed 75 percent of your --

A Yes, sir.

Q -- professional time?

A Yes, sir. And they overlap. They go together very neatly.

Q Showing you what has been previously marked for

purposes of identification Defendant's Exhibit A, could you identify that for me, please?

A Yes, sir. That's my curriculum vitae revised June 27, 1989.

Q And for the purposes of the benefit of the Jury, a curriculum vitae is your resume?

A Yes, sir.

Q What is the trigeminal nerve?

A The trigeminal nerve is the fifth of twelve cranial nerves that run out of the front of the base of the brain or the side of the base of the brain. They are the nerves that we communicate with primarily and move are upper -- our neck and face with. It's the nerve that has to do with sensation in the front of the top of the head, in the front -- in the face down to the chin and in the front of the mouth. It also has to do with jaw motion. So that your jaw muscles are controlled by the trigeminal nerve.

Q Where is its origin?

A The origin is in the middle of the pons. The pons means bridge. It's the section of the brainstem that connects the mid brain from which everything comes in and out of the fore brain to the medulla,

which is a connection to the cerebellum and a connection to the spinal cord.

Q You indicated that the trigeminal nerve has a couple of functions, sensation and motor function?

A Yes, sir.

Q Is that correct? I want you to look at, perhaps show for the Jury -- to the Jury an anatomical drawing of the trigeminal nerve and see if you can explain that to the Jury. (Exhibit B)

A Can you see that? (Directed to video operator.) All right. This is the left-sided trigeminal nerve. This is the base of the skull, the medulla. The area called the pons is this bulbous area.

The nerve comes out of the pons or goes in, whichever direction it's going, and then along the floor of the temporal bone -- that would be on the left side as here, deep to here, is an area called the gasserian ganglion or semilunar ganglion. It gives off three branches or receives three branches, the first, second and third division. And these branches come from the upper, central and lower part of the face.

There's also a motor branch, which runs

the jaw, which is coming out not seen well here in this area running along underneath this ganglion and then down and up the muscles that control your jaw.

Q So by that anatomical drawing we have three divisions?

A That's correct.

Q Of the trigeminal nerve?

A Yes.

Q Thus the prefix tri?

A Correct.

Q Where would division one run?

A This is the first division, which is the top of the head in front of the vertex on down to the -- essentially to the middle of the eye and sparing the temporal area. So it's -- if you can see me as well as the -- can you see me on that? It's this area where my hand is, the upper head and face from the middle of the eye upward.

The second division is from that area but it goes into the temporal area, the area of the temple, down to -- and the front of the mouth and the upper lip -- those, and the cheek.

And the third division is the lower

cheek and the jaw and the tongue and the lower lip.

Q Showing you what has been identified or marked for purposes of identification as Defendant's Exhibit C is another schematic showing the distribution of innervation.

A Yes. And that's pretty much what I just told you about. The green is V-1, the blue or the purple I guess it is V-2. Although I would disagree with the drawing here. And the third division down below. This is not my -- what we find clinically.

But this is Frank Netter, who's an excellent artist and physician, and satisfactory for general medical people but not for neurosurgeons. It's 1986. But the lines -- the separations are a bit different. But generally lower jaw, cheek and temple, forehead and upper face are three, two and one.

Q Okay. Thank you.

MR. DELBAUM: I'd like to object and move to strike the exhibit that the Doctor was just referring to as not anatomically representative.

BY MR. DAPORE:

Q Let me ask you this, Doctor. Are they anatomic representative? Generally anatomically representative of the distribution of innervation of Division 1, 2 and 3?

A They are generally, but they're not accurate for the --

Q In what respects are they inaccurate?

A They are inaccurate, because the second division goes into the temporal region. And I can show you better than talk about it. Are we still on this picture, Mr. Murphy?

The junction between the first and second division is right through the eye as far as we can tell clinically. And the second division also goes further up into the temple. And the third division I've not seen changes on the side of the head like this. This doesn't happen.

The motor branches *go* up there, because some of the jaw muscles go up there but not sensory, not for feeling.

Q Which branch or which division of the trigeminal nerve would control the corneal reflex?

A The first and part of the second.

Q And when we talk of corneal reflex --

A And that's in disputation. It's not as clear-cut as we'd like to be. This is our findings over the years, which have been in disagreement with old ideas just as that is an old idea.

Q What is corneal reflex?

A The cornea is the tissue that covers the part of the eye where you look through, the pupil, and the surrounding dark area. And the reflex is achieved by stimulating that very lightly. And we do it with a single wisp of cotton and touching the cornea, the upper half and then the lower half.

And you get a patient -- I should have explained it more completely. The patient will respond by blinking, by flinching. And you can see the the flinch and the blink. And you also ask the patient how it felt. So it's both objective in a sense and subjective.

Q Is there a difference between a corneal reflex and a blink reflex?

A The blink reflex is an electrophysiologic test, which is just as the corneal reflex is both sensory for trigeminal and motor to move the eye, the blink reflex is the same -- the same thing. But it's an electrophysiologic.

Q It's measured by a machine?

A Yes, sir.

Q In order to have a decreased corneal reflex, where would there have to be injury to the trigeminal nerve?

A The injury would have to be in V-1 and V-2 and, therefore, would have to be in both of those branches or proximal, that is, in the ganglion I showed you or in the nerve itself or in the brainstem where the nerve -- the pons where the nerve is coming out.

Q When you say the ganglion, that's the junction of the three divisions?

A Yes, sir.

Q Was that area of the ganglion involved in the surgery performed by Doctor Levine on Mrs. Golden?

A No, sir.

Q Where is that junction located anatomically?

A That junction is deep to the temple. If I were to put a line deep to my finger here, to my eye and another line deep to my finger here just in front of the ear, where those points come together is where that area is.

Q Would be inside the skull itself?

A Inside -- yes, sir. Now, if you got the branches there would be just little canals just in front of these -- of this area.

Q Where does the division of V-1 exit the skull to come out under the tissues covering the skull?

A From the superior orbital fissure.

Q And could you demonstrate that by pointing to it on your forehead?

A It would be where the eye nerve come out in order to move your eye. *So* it is deep to here.

Q So the division of V-2 that would innervate the eye, where would it exit?

A Another foramen. And then the third division is yet another foramen. So the different openings that go from medial to immediate to lateral.

Q What is trigemina -- trigeminal neuralgia?

A Trigeminal neuralgia is a face pain problem. And typically it occurs on one side, but in time five percent of people will get it on both sides over years. It's more common in women than in men slightly, about three to two. It's more common on the right side of the face than the left side of the face, again by about three to two. And it varies in various series.

It's more common in the lower-central or lower and central face than it is in the upper face. About 95 percent is cheek and the jaw. It comes out of the blue generally. The first attack people remember many years later of sharp jabbing, the worse pain I've ever had in my life. They will often refer to it as like electrical shocks. And when they tell you that, they won't touch their face, because that's one of the things that will bring it on. And they will move the hands like electricity. And they'll talk about electricity, knives in their face and so forth and so on.

They often think that it is a dental problem. They go to the dentist first -- 80 percent of our patients over the years. Usually they can find a position that will make them more comfortable. And rarely do they have problems being awakened from sleep with it. But they never know when it's going to happen. They do find out things that will bring it on: Cold air, cold water on their face, air conditioner, brushing their teeth, shaving, things like that. Putting make-up on, putting lipstick on for a woman can

set off an attack.

They usually last very briefly, a matter of seconds. But the attacks of repetitive jabbing can go on for an hour. Historically, it has been described as being so-called idiopathic, which just means that we're ignorant about it.

And there's been a lot of evidence that developed over the years to show that it is due to problems with the trigeminal nerve where it comes out of the brain before it goes to the ganglion that we were talking about -- or it comes from the the ganglion. These are mainly vessels, blood vessels. It's associated with the aging process, because blood vessels get longer as we get older. And they're all around the base of the brain here. They start to loop and beat on this nerve, as they beat on the other nerves and cause trouble with hearing, balance and moving your face and swollowing and all kinds of problems as we age.

Treatment has generally been over the years medical, starting in 1938 when they got the first good medicine for it that worked at all or surgical. In the past they used to do lots of injections, but there have been ways of cutting or

injurying a nerve one way or another which have varied.

And then the more modern treatment has been to move away the blood vessel that is causing the pain by using microsurgical techniques, because we are dealing with a nerve that's about that big around and blood vessels that are usually smaller.

Occasionally tumors cause it but usually pushing a blood vessel against the nerve. And multiple sclerosis is a disease that causes it, not by a blood vessel but by having an area of the disease in that part of the nerve. That's probably more than you wanted to know about trigeminal neuralgia.

Q If there were some injury or compression to the infraorbital nerve, would that produce symptoms throughout the trigeminal distribution V-1, V-2, and V-3?

A No, sir. Could not. Would not.

Q And why is that?

A Because you get a local syndrome of the infraorbital nerve, which is a restricted nerve with a restricted area of distribution. It's a

branch of a branch of the trigeminal nerve.

Q The infraorbital nerve is a branch of a branch?

A Yes, sir. Yes, sir.

Q I'm going to ask you some questions with respect to opinions you hold in this case. And throughout all of those questions, I want you to keep in mind that I'm asking you these questions to a reasonable degree of medical probability, whether it's more likely than not the case. And I don't want to keep repeating that phrase.

A Sure.

Q Because it's a lot of words and I get tongue-tied. I'm going to ask you this: Do you have an opinion whether Mrs. Golden has a trigeminal neuralgia?

A Yes, I do.

Q And what is your opinion?

A She has some characteristics of typical trigeminal neuralgia that I mentioned and described to you. But she has, as we see in many patients, a part of this syndrome

She also has a more constant pain, which is -- which blurs into what we call atypical trigeminal neuralgia. And she also has some loss of function, which we see in about a third of

patients which may in her case mean trigeminal neuropathy, which just means decreased function, i.e., numbness. I would categorize her as having trigeminal neuralgia with a lot of atypical characteristics or atypical trigeminal neuralgia with a lot of typical characteristics. She's sort of right in the middle. But it's not infraorbital. It's beyond the infraorbital nerve. And that's very important here.

Q Do you have an opinion whether the type of trigeminal neuralgia that you just described as being present in Mrs. Golden is as a result of the surgeries performed by Doctor Levine?

A Yes, sir.

Q And what is your opinion?

A That because of the distribution of the pain and the distribution of the findings on examination and to some degree -- to a large degree because of the latency chronologically, this has no relationship to the operation that -- the blepharoplasty and the further revision for ectropion performed by Doctor Levine.

Q And when you say that it's because of the distribution, what is it about that distribution

that causes you to say it's not related to the surgery?

A She's had pain in the eye, pain in the cheek, pain going well out laterally and up into the temporal, pain in the tongue, pain in the lower lip, and I think some other pain in the jaw. This is beyond the distribution of the infraorbital nerve, which is the only nerve that's up there at all.

She had numbness -- and I haven't seen her -- I don't know her as of now -- which was documented in the upper head and forehead into the V-1 distribution and in the V-2 distribution and a decreased corneal reflex, which again are well beyond the distribution of the infraorbital nerve.

Q Anatomically, where would the infraorbital nerve be located in relation to the surgical field for a blepharoplasty?

A I'll take off my eyes, my artificial eyes. The blepharoplasty was performed in the lower lid. And so you have an area right here. The infraorbital nerve -- if you will put your finger on your cheekbone, you can tweak it if you go down -- way down here and then come up. You can -- you can push on that nerve where it comes

out. And then it spreads out in this area from there. So it's pretty far away.

Q You are talking about approximately --

A A couple fingers breadths.

Q About an inch, inch-and-a-half?

A And fairly wide fingers. Inch, inch-and-a-half.

Q You also indicated something about the latency. What is it about that?

A Her pain began approximately two months after her second operation. Now the later records say that it was three weeks, but the earlier records say two months. And July 22nd, and then the pain starting sometime in SEPTEMBER December.

Q And when you say the earlier records, you refer to the records of Doctor Salanga from the Cleveland Clinic?

A Yes, sir.

Q And then the later records of Doctor --

A That would be Doctor Daroff, I believe. Yeah, Robert Daroff.

Q Who saw her in 1988?

A Yes, sir, February of '88.

Q Almost nine months after the second surgery?

A Yes.

Q What is it about that time relationship of the surgery to the onset of pain that helps you to rule out that involvement?

A The longer the delay the less likely there is an involvement. And after five or six weeks, we pretty much discount things. We started to look at this a while ago, because people were getting their heads bumped all the time and one wonders about relationships. But two months would be outside our -- what our information would give us as being causal.

Q **Do** you have an opinion whether an injury to the infraorbital branch of the V-2 division, an injury to that branch alone, either by surgical interruption **or** scar formation causing compression would produce the complaints we have by Mrs. Golden?

A Yes, sir, **I** do.

Q And what is your opinion?

A That they would not cause the complaints or the findings, because they are beyond the infraorbital nerve distribution.

Q Have you ever in your career seen a case of primary injury to the infraorbital nerve produce

symptoms in all three divisions of the trigeminal nerve?

A No, sir, I've seen many injuries to this nerve --

Q In what context?

A -- over the years. In the context of people who have had ear, nose and throat operations, primarily the Caldwell-Luc operation where the maxillary sinus is windowed open to drain it. And about 15 percent of these people get an infraorbital nerve syndrome which is very localized. And I see maybe two to four of these per year.

Q What treatment options does Mrs. Golden have available to her for her trigeminal neuralgia?

A Well, one is to stay on the Tegretol, which is helping her apparently. But I don't know that. I have no firsthand information about that. The other is to try some of the other medicines for this problem. And thirdly would be an operative procedure.

Q The records that you have reviewed from her treating physicians, what do they tell you about the use of Tegretol and the patient's response?

A My understanding as I remember it is that the

Tegretol has -- here's Doctor Daroff saying: Doctor Salanga started her on Tegretol and this seems to have helped.

Q Does that help you in any way in diagnosis of whether this is a trigeminal nerve neuralgia?

A Yes, sir. This is one of a -- sort of a diagnostic test for us in patients who are in this grey zone between atypical trigeminal neuralgia, so-called atypical facial pain, which I haven't talked about, and which she doesn't have and you can forget about, and trigeminal neuralgia be present. If they respond to Tegretol and then it stops working, if the patient did respond, the implications are that an operation is more likely to help.

Q What would be the success rate for an operative procedure for relief of these complaints by Mrs. Golden?

A If this were a classic trigeminal neuralgia less than ten years without a prior constructive operation, you are talking 90 plus percent.

MR. DELBAUM: Objection, and move to strike as non-responsive to the question.

A With atypical symptoms, the numbers drop down.

Probably 60 to 70 percent over time.

Q And your opinion is that she has a cross-over between these two syndromes?

A Yes, sir.

Q And could you estimate a percent of relief that she could anticipate where she'd undergo a surgical procedure?

A Only as one of a hundred patients. And I would say that she's somewhere between that 60, 70 and 90 percent,

Q So the likelihood is that she would get a very good result from such a surgical procedure.

MR. DELBAUM: Objection.

A Something better than 60 percent.

MR. DAPORE: I have nothing further for you, Doctor. Thank you very much.

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CROSS-EXAMINATION

- - - -

BY MR. DELBAUM:

Q Good morning, Doctor Jannetta.

A Yes, sir.

Q My name again is Charles Delbaum. I'm representing the Plaintiffs in this action.

Doctor Jannetta, I want to ask you some questions about your background and then about your opinions.

First about your background. As I understand it, you almost always testify for the defense in litigation; is that correct?

A I think that we have discussed this before. And I have testified for plaintiffs three times that I can recall and more than that for defendants.

Q It's many more than that for defendants, isn't it?

A Yes. Yes, sir.

Q You yourself have also been the subject of suits for alleged medical negligence; is that correct?

A Yes, sir.

MR. DAPORE: Objection, move to strike as irrelevant.

BY MR. DELBAUM:

Q If I understand the nature of your experience and your work as a neurosurgeon and previously as a surgeon, you don't generally and haven't generally worked with plastic surgeons doing cosmetic surgery; is that correct?

A I don't do direct cosmetic surgery as they do. I have done a lot of work with plastic surgeons. I

now have colleagues that do a lot of that. I have a big department and we have superspecializing.

Q My question, though, is whether you have done work with plastic surgeons doing cosmetic surgery?

A I did as a resident in surgery.

Q Many years ago?

A Many years ago.

Q You, yourself haven't seen a blepharoplasty performed in a long time, have you?

A That's correct, sir.

Q And you've never been involved in a surgery where evacuation of a hematoma under the eyelid was required, have you?

A To my recollection, no.

Q Is it your opinion, Doctor -- and again to a reasonable degree of medical certainty -- that there was or was not a hematoma following the first surgery, the one that was on June 24th, 1987?

A There was a swelling described, which was said to be about the diameter of a golf ball and about as third as deep as a golf ball apparently over the incision. I wasn't there, of course. It was ecchymotic, which these things always are. And I

would really defer to a plastic surgeon to answer that. I don't think it's really critical to this problem whether it was tissue, infusion of blood or whether it was discrete hematoma.

Q Doctor, do you have an estimate of approximately how wide a golf ball is?

A Less than an inch-and-three-quarters.

Q Okay. *So* that --

A I don't know exactly. Do you know? Anyone know? I guess the English and American golf ball is different. I'm not a golfer. English is smaller I know.

Q Is it your understanding that a golf ball -- if half a golf ball were placed under the eye in the approximate location of the surgical work that was done on Mrs. Golden in June of 1987 that would extend to the location where the infraorbital nerve exits the skull?

A My understanding would be that it would not. And my understanding also is that it was a third of a golf ball. So it would be a smaller diameter than what you are talking about.

Q Your understanding --

A Just to establish that.

Q -- is that the width of the swelling as opposed to the height was only a third of a golf ball?
A No, the height was a third.
Q But the width was a golf ball?
A That's what was said, yes.
Q My question was whether that width would be sufficient so that it would extend from the operative site to the area where the infraorbital nerve exits the skull?
A I think it would not.
Q Am I correct in understanding that you do not know how far on the cheek the scarring from these surgeries extended?
A That's correct.
Q Would you agree with me that in a routine blepharoplasty followed by substantial swelling the swelling could extend to an area where the infraorbital nerve is?
A I would defer to a plastic surgeon in this regard. I think any swelling could *go* anywhere.
Q Doctor, I'd like you to pick up Exhibit B again, if you would. And I'll ask you to show that to the camera man again.
Q Are you able to pick that up?

A I'm sorry. Here you go.
Q In that diagram there's an indication that one of the branches from the infraorbital nerve exits this skull and then goes into the area right under the eye socket; is that correct?
A That's what this drawing shows.
Q Could you show the Jury where that is?
A This is the infraorbital nerve here coming out of the bony canal.
Q If I can stop your pen. That's where it comes out; is that right?
A Right. That's on this drawing where it comes out. Not in a human, all right.
Q Okay. Go ahead. And then the branch I was referring to goes up on the diagram?
A I presume you are referring to this branch, this thin branches.
Q So at least according to this diagram one of the branches of the infraorbital nerve goes up into the area right under the eye socket?
A That's correct.
Q Would you agree with me that incisions near the inferior orbital rim may damage the infraorbital nerve?

A Not the infraorbital nerve. There are cutaneous nerves everywhere. Wherever you cut the skin, you got nerves in the skin. So any incision in that sense is going to damage a nerve.

Q But as far as the infraorbital nerve, your testimony is that incisions near the inferior orbital rim of the eye socket cannot damage the infraorbital nerve?

A That's correct.

Q Would you be willing to concede that competent physicians could have an opposite opinion?

A Yes.

Q And is it also correct that the incisions from Mrs. Golden's two surgeries were near the infraorbital rim?

A Yes, sir.

Q Am I correct in understanding that scarring of tissue near the infraorbital nerve can cause a neuropathy or neuralgia?

A I'm sorry? Can you repeat that again?

Q Yes. Am I correct in understanding that scarring of the tissue near the infraorbital nerve can cause neuropathy or neuralgia?

A Yes.

Q And am I also correct in understanding that a hematoma can cause scarring of tissue near a nerve?

A Yes, that would be true.

Q One of the matters that Mr. Dapore asked you about was the delay between the surgeries here and the patient's report of a pain pattern that we've been talking about. With respect to that, isn't it true, Doctor, that there are instances where scarring near the infraorbital nerve causes infraorbital neuropathy which is not recognized until as long as three months after the surgery?

A That possibly is true. But the longer it goes, the less relationship. And if you're talking about a direct injury to the infraorbital nerve, that's fine. But that does not apply to this case, because this lady does not have infraorbital nerve syndrome. And just so you understand that and don't apply it to this patient, then I would agree with you.

Q Well, as a general matter, though, including for this patient if -- let me start that question again.

A Sure.

Q As a general matter, if scarring near the infraorbital nerve, in fact, causes infraorbital neuropathy, which you do not believe this patient has --

A That's correct.

Q -- then the onset may be as long as three months after the surgery?

A I presume that may be so, because anything can happen. The patients that I have seen usually have this in the hospital when they awake -- awaken from their operation or before they leave the hospital or within a matter of a few weeks.

Q But even in your --

A After five or six weeks we discount it.

Q Isn't it true that some of your patients have been as long as three months after the surgery before the pain from scarring of tissue near a nerve was recognized?

A Yes, we've talked about that before and I guess mentioned that to you, as a matter of fact.

Q Okay. Maybe I misunderstood what you just said. Is it true that some people can have anatomically unusual or unusual nerve distributions?

A Yes, sir.

Q And if I understand your testimony that you gave earlier today correctly, your feeling is that Mrs. Golden does not have a typical picture of any particular known disease or illness entity; is that correct?

A No. What I tried to say -- and I'm sorry if I didn't make myself clear -- was that -- that if we look at the entities, she is between two entities. And we see this very frequently. It just doesn't have a name yet.

Q In formulating the opinions that you've been providing as a witness here, you took into account the information in the Cleveland Clinic records from the fall 1987, did you not?

A Yes, sir.

Q And did you also take into consideration the information in Doctor Daroff's reports?

A Yes, sir.

Q In both of those sets of reports and information, ones from the Cleveland Clinic and from Doctor Daroff, those physicians concluded that her left corneal reflex was diminished; is that correct?

A I think that's correct. I'd have to look at this

one more -- one more time to be sure.

Q Please take your time to do that.

A Dr. Daroff mentioned on February 23rd, 1988 a slightly depressed left corneal, parenthesis, after she took out her contact lenses, end parenthesis. Doctor -- I'm sorry -- Salandra?

Q Salanga.

A -- Salanga mentioned the decrease left corneal reflex on his examination of October 29th, 1987. Those are the only two that show -- in that perspective, yes, the answer is yes.

Q But am I correct in understanding that you decided that those doctors were in error and that the left corneal reflex probably was normal?

A No, sir, I don't recall saying that. This may have had to do with the ectropion, I think I may have said, which would decrease the amount of contraction you might get.

Q You do recall -- and I think you've referred to today that I had the opportunity to conduct your deposition --

A Yes, sir.

Q -- here in Pittsburgh approximately two-and-a-half months ago?

A Yes, sir.

Q And the testimony you gave at that time was accurate and truthful to the best of your knowledge at that time?

A Yes, sir.

Q In the course of that deposition I asked you whether in your report you had stated that the corneal reflexes appeared to you to be within the range of normal. And I asked you what that statement is. And I would like to know whether you recall that your answer at that time was: Having at that time reviewed those records, I felt that she had enough corneal reflex that I would consider it normal,

A That was my response at that time. You were asking me about their -- their answer, not about my answer.

Q I've asked you both --

A I've given you their answer, and I will stick with what I said at the deposition. It's not important here as far as -- in fact, the importance is that it again brings it beyond the infraorbital nerve if it is truly decreased, just so you understand that.

Q I just want to get your testimony clear. Is it your testimony that your opinions are based on the left corneal reflex being normal or diminished?

A My opinion is strengthened if it is diminshed quite truthfully.

Q Would you agree with me that Mrs. Golden currently has pain caused by some problem with her trigeminal nerve?

A Yes, sir.

Q And you don't dispute the fact that this problem with her trigeminal nerve began within two months of the surgeries performed by Doctor Levine, do you?

A That's correct.

Q But your opinion is that it is just a coincidence that her problems with the trigeminal nerve began within two months of these surgeries?

A Yes, sir.

Q Is that correct?

A Would you also agree with me, Doctor, that it's not unusual for competent physicians to have reasonable differences of opinion about medical matters?

A I think I've already answered that once before.

Q If you did I'm sorry for asking it again.

A Wasn't I asked that before?

Q In general, it is possible?

A It is possible.

Q Thank you very much. But not about anatomy. That's incredible. The distribution of the. infraorbital is not a point of argumentation.

MR. DELBAUM: I don't have any other questions. Thank you, Doctor.

THE WITNESS: Thank you.

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REDIRECT EXAMINATION

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BY MR. DAPORE:

Q Just to clear up a couple of questions asked on cross-examination, Doctor Jannetta, I'm going to show you the records from Mt. Sinai Medical Center from the first surgery, records that had been provided to you earlier. And if you would read the nursing progress note of the date after the first surgery at 11 a.m. First, take a look at it for yourself, and I'll ask you a question.

A I can't read a couple of words but the first half of it I can read quite easily.

Q Is there a reference there to -- with respect to swelling?

A Yes, sir.

Q And could you read that for the ladies and gentleman of the Jury, please?

A Why don't I just start with the beginning of the note. At 11 o'clock on June 24, 1987: Received, awake and alert to U.S.U. Scant drainage from lower lid. Left incisions, which would be blepharoplasty incisions, suture line intact, no marked swelling. Ice compresses on both eyes.

Q Do you recall what time it was that this surgery was completed?

A It was early morning, and I don't know the exact time.

Q Let me see if I can find the operative note there for you.

A All right. You probably can find it more easily than I can.

Q In fact, it's on the anesthesia records.

A Fine.

Q Thank you. At the bottom, very bottom of the page.

A It's -- I think it says 10 o'clock to recovery

room.

Q So that --

A So 8:30 to 9:55 was the duration of anesthesia. 8:45 to 9:46 was the duration of the operation. And she was out of the room by 10 o'clock.

Q And by 11 o'clock we have a nursing observation of no significant swelling?

A That's correct.

Q If there were scarring and swelling near the infraorbital nerve such as to cause a neuralgia of the infraorbital nerve, would it produce a V-1, V-2 and V-3 distribution neuralgia and neurapthy?

A No, sir.

MR. DELBAUM: Objection.

A It would not.

Q Why do you say that?

MR. DELBAUM: Objection.

A It does not do it. It is within the -- it would have to be within the distribution of the infraorbital nerve. And her problem has to be proximal to the infraorbital nerve.

Q You were asked a question on cross-examination about abnormal nerve distribution and whether that could be present in a patient. Do you recall

that?

A Yes, sir.

Q Is there any way that you as a physician or a surgeon would know of any abnormal distribution or variance in anatomy preoperatively?

A **No,** sir.

Q You were asked some questions on cross-examination with respect to corneal reflex. And that is the cotton wisp test, and there's a gross examination by the person performing the test; is that correct?

A Yes, sir.

Q What is the difference between that and a blink reflex again?

MR. DELBAUM: Objection.

A Much of it will depend on the way the tests are performed. There are variations in testing, variations in interpretation, both of the clinical test and of the blink reflex. And people think that blink reflex means different things.

We test the -- I can only speak really for what I find and what I've taught my group, because it's been useful. And that is that you touch the corneal. You don't touch the white of

the eye, and don't hit them with a handkerchief. You touch them with one wisp of cotton in the lower half and in the upper half. And see how they flinch and you see how much they blink and you ask them how it felt compared to the other side on the lower half and the upper half. That is a very precise corneal reflex.

If someone hits them with a Kleenex and there's a difference, there has to be a marked difference if it's at least done carefully, because there's much more impulse.

Q The blink reflex is the electrophysical test?

A Yes, sir.

Q And that's not done by -- that's not measured by a person's observation, it's measured by a machine?

A That's correct.

Q Are you aware of whether or not a blink reflex was performed on Mrs. Golden?

A Yes, there was a blink reflex performed. I haven't seen the primary data, but it was interpreted as being normal.

MR. DAPORE: I have nothing further. Thank you.

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RECROSS-EXAMINATION

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BY MR. DELBAUM:

Q Doctor, I just have one or two --

A Sure.

Q -- questions I'd like to ask you to attempt to clarify further these matters. In relation to the post-surgical swelling, which we've discussed and we talked about whether it was -- near enough to the area of the infraorbital nerve to damage it even if it was the size of a golf ball, you've just been asked about a nurse's note from 11 a.m., which was approximately an hour-and-a-quarter after the end of the operation; is that correct?

A That's correct.

Q Now, it is possible with blepharoplasty surgery, is it not, that post-operative swelling, which is not evident an hour-and-a-quarter after the termination of the surgery can develop subsequently?

A You asked about swelling?

Q Yes,

A Yes, sir, it is possible.

MR. DELBAUM: Thank you. I have

nothing further.

MR. DAPORE: Thank you, Doctor Jannetta.

THE WITNESS: Thank you.

MR. DAPORE: Doctor Jannetta, for the record, you have the right to review the video tape. You must do that now before the video tape person leaves. You can also waive your right to review.

THE WITNESS: I defer to your judgment.

MR. DAPORE: You may waive as far as I'm concerned. You also have the same option with the transcript. Our court reporter did a fine job with your discovery deposition, so I would recommend that you waive as well.

THE WITNESS: I will.

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(Thereupon, at 11:20 a.m., the within deposition was concluded and signature was waived.)

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