state of Ohio,)
) SS:
county of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

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Jack Rogers, et al.,)
)
Plaintiffs,)
)
vs.) **Case No. 390671**
) **Judge Curran**
)
University Mednet, Inc., et al.,)
)
Defendants.)

- - -

DEPOSITION OF LOUIS KEPPLER, M.D.

- - -

Deposition of LOUIS KEPPLER, M.D., called by the Plaintiffs for examination pursuant to the Ohio Rules of Civil Procedure, taken before Phyllis L. Englehart, RMR and Notary Public in and for the State of Ohio, at the offices of Louis Keppler, M.D., 2709 Franklin Avenue, Cleveland, Ohio, on Tuesday, March 20, 2001 commencing at 5:30 p.m.

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APPEARANCES:

On Behalf of the Plaintiffs:
Kevin T. Roberts
Lakeside Place, Suite 450
323 Lakeside Avenue
Cleveland, Ohio 44113

On Behalf of the Defendants:
Susan Reinker
Bonezzi, Switzer, Murphy & Polito
1400 Leader Building
Cleveland, Ohio 44114

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LOUIS KEPPLER, M.D.
having been first duly sworn, as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION

By Mr. Roberts:

Q Would you please state your full name for the record.
A Louis Keppler, M.D.
Q Doctor, you've been deposed before, haven't you?
A Yes.
Q About how many times?
A I don't know. 15 times maybe.
Q So I don't need to explain the basic rules of the deposition to you?
A No.
Q Okay. Thank you. What did you do to prepare to render an opinion in this case?
A I reviewed the material, including hospital records, letters and office notes and a couple of transcripts of some depositions.
Q Do you have everything you reviewed in front of you today?
A Yes.
Q Could I see it for a minute?

A Sure.
Q Thanks. Did you get a chance to review the actual MRI in this case taken October 23 '98?
A I looked at it.
Q Did you see the films or just the report or both?
A Both.
Q Do you have any disagreement with the radiologist's reading of that particular film?
A Not that I can -- no, no specific disagreement. I mean I didn't study the MRI closely, but from what I saw, it was consistent with what he wrote.
Q I see you have Dr. Conomy's report of January 5th, 2001?
A Yes.
Q Do you know Dr. Conomy?
A Yes.
Q He's your downstairs neighbor?
A Yes.
Q Have you had any discussions with him about this case?
A No.
Q You reviewed two volumes -- actually one volume of the Mednet chart, which dates back to

May 1965. Did you actually review this whole thing?

A No.

Q Do you recall which sections you did review?

A I reviewed the sections in and around the time we're going to be discussing and some period of time after that.

Q All right. You have the Lake West Hospital chart for Jack Rogers' admission for necrotizing fasciitis, correct?

A That's correct.

Q Did you get to review that whole thing?

A I perused it, yes.

Q Did you read the operative notes?

A Yes.

Q Is there any indication that when they debrided Mr. Rogers' right leg they found a ruptured popliteal cyst?

A Surgery wasn't for an exploration of the popliteal cyst.

Q I understand that. But wouldn't they have found it on that debridement?

A No.

Q Looks like that particular operative note is not in your record.

MR. ROBERTS: Maybe you took it out and looked at it. I don't know. It's not there.

A I reviewed -- I did read the operative note.

MS. REINKER: There it is.

MR. ROBERTS: Is it the next page?

MS. REINKER: It's under the tab for operative note. There's a tab for the debridement, and there are different parts in there.

MR. ROBERTS: Okay. You have it set up differently.

Q Just so we're talking about the same thing, I'm handing you an operative report from Lake Hospital System dated 10-26-98.

A Right.

Q The preoperative diagnosis includes ruptured popliteal cyst. Postop diagnosis doesn't refer to popliteal cyst, right?

A Yes.

Q Based on the description of what Dr. Posch did in the operation, did you expect him to find the ruptured popliteal cyst?

A No.

Q Why not?

A Well, when we excise popliteal cysts, it's prior to rupture. It's a thin wall of synovial tissue, and actually when we excise the popliteal cyst, we take great care trying not to rupture the cyst with our dissection.

Q Why?

A Because once you rupture it, you lose the anatomy of the cyst. So it would be very, very difficult if -- in a case of a ruptured popliteal cyst. I would never -- I think it would be very difficult to find evidence of the cyst postrupture.

Q You wouldn't find any fragments of membranous tissue?

A No.

Q Cartilage, anything?

A No. It would be very, very difficult. It's difficult enough to do a dissection of the popliteal cyst with it intact, to dissect the walls of the cyst from the overlying normal tissue. After a while, everything starts looking the same.

Q Okay. You've had a chance to look over all the records of October '98 for Mr. Rogers, right,

including Dr. Posch's notes?

A Yes.

Q Did you get to go back to October 8th when he saw Dr. Kakish?

A Yes.

Q Would you agree that this presentation here was not typical of a ruptured popliteal cyst?

A No, I wouldnot.

Q Didn't the pain here develop chronically? It wasn't an acute rupture?

A My understanding of this is that it was consistent with a history for a ruptured popliteal cyst.

Q Well, one of the signs of a popliteal cyst is a sharp pain, isn't it, a traumatic rupture?

A Not necessarily.

Q But typically, I'm not saying every instance, but more often than not, isn't it an acute incident type of traumatic incident?

A No, it's -- I mean I think that his history of having a time when his symptoms developed over a short period of time and were related to a particular mechanical event.

Q What event was that?

A That was hyperflexion of his knee.

Q Caused by what?
A He was kneeling or squatting.
Q Didn't he report that his knee had been aching for several days the day before he was kneeling and squatting?
A That's -- I wouldn't be surprised that it was.
Q Why?
A Because typically a popliteal cyst is something that develops because of an underlying intra-articular pathology. So when people come to me with a popliteal cyst, they may have complaints associated or may have complaints associated with the swelling they perceive.

And they may implore me to excise their cyst, but it would not solve their problem because the underlying problem may be osteoarthritis, may be a torn meniscus or something else going on within the knee.

Q **A** popliteal cyst generally presents in the medial side of the knee, doesn't it?
A It can be medial or lateral.
Q Which is more typical?
A Posterior medial.
Q And is there also a kind of outpouching that's a hallmark of the popliteal cyst?

A If it's intact.
Q If it's intact, it hasn't ruptured, you see kind of a golf ball under the skin kind of a bulging?
A It may be hard. Depends on the patient's size of their leg.
Q How much fatty tissue they have and so on?
A Yes.
Q Have you ever seen Mr. Rogers' legs? Have you ever seen pictures of his legs?
A No, I haven't.
Q He's described as a pretty skinny guy.
A Okay.
Q Dr. Kakish didn't note any outpouching or bulging in his knee October 8th, did he?
A Not that I recall.
Q You can look at the records.
A Sure. It's my understanding that he had other joint pain as well.
Q Look at your copy of the records.
A Sure.
Q I'm looking at what's marked as page 144.
A Okay.
Q Which goes on to 145.
A Right.

Q The subject of which is the history, begins, "The patient states his right hip and knee have been aching recently."
A Right.
Q "And objectively examination doesn't reveal any swelling about the right hip or knee," right?
A Yes, that's correct.
Q **A** popliteal cyst in someone with a fairly thin leg, doesn't have much body fat, you would expect to see a pouching, wouldn't you, out-bulging?
A It may or may not have been appreciated by Dr. Kakish at the time. And the presence or absence of the swelling is very dependent -- is a day-to-day thing.

I've had patients make an appointment to see me in my office for a popliteal cyst or swelling. By the time they get in to see me, it's resolved.

Q Why is it resolved?
A Well, it depends on the patient's activity level. You can think of it -- pardon me one second.
Q Sure.

(Brief recess)

Q What were we talking about? Outpouching that goes in and out.
A Right.
Q Why would it resolve itself? Why would a popliteal cyst resolve itself?
A Because the knee effusion, the synovial fluid goes -- some people have an effusion that's palpable when you examine the front side of the knee, and that comes and goes associated with activity level, things like that, how irritated the knee is. And the same thing goes with the popliteal cyst. It may come and go based on the patient's activity.
Q Why does activity cause it to go away?
A Because if you have, let's say, a degenerative tear of your meniscus or you have osteoarthritis, if you're up on your knee, active, your knee is going to react to that additional stress and may make additional fluid, whereas rest will allow that to resolve.
Q Of course, we're talking about a nonruptured cyst at this point.
A Right.
Q If it ruptures, that same mechanical situation applies? If it's ruptured and you continue to

use your knee, can you irritate it and cause more fluid to come out?
A. No. If it's ruptured, typically there's an imposed period of rest because of the discomfort associated with the cyst. But again, if the guy was prone to have an effusion, the knee responds to irritants, you would see an effusion in the joint depending on the activity.
Q. Do you have any opinion as to what was causing an effusion of the popliteal cyst in Jack Rogers?
MS. WINKER: Are you talking about two different things? **A** knee joint effusion is different from a popliteal cyst. I think he was using an example.
Q. I'll make it simple. Do you have any opinion as to any root cause of a popliteal cyst in Jack Rogers right now?
A. Typical causes are associated with degenerative changes in the joint.
Q. Why does it typically present before rupture on the medial side of the knee?
A. There's sort of a weak spot in the joint capsule in association with escharotic tendons.

Q. How would it get to the posterior lateral side of the knee?
A. There may be a weak spot there as well.
Q. How often have you seen that?
A. I don't know.
Q. Is there any case in particular where you can say I did see it in this person?
A. Yes. I did treat, I actually excised a large synovial cyst on a patient, I believe it was actually lateral, within the past couple years.
Q. You say synovial cyst. Do you mean a ruptured or popliteal cyst?
A. Yes.
Q. Are there different types of cysts in the knee, one being popliteal and the others having different names?
A. We use -- I think we could use the name Baker's cyst, popliteal cyst, synovial cyst all interchangeably.
Q. Why did that person have it on the lateral side of the knee? Did you ever determine that when you excised it?
A. There was -- we dissected down to the joint capsule, and there was a rent or weak spot in the capsule at that point.

Q. So you can recall seeing one specifically in how many patients with a popliteal cyst?
A. Popliteal cysts, the ones I treat operatively, I've probably only operated on a half dozen popliteal cysts in my career.
Q. How many have you diagnosed in your clinical practice?
A. I see them frequently in association with degenerative disease of the joint.
Q. You say degenerative disease of the joint. You mean what aspects of the knee joint?
A. There's a spectrum of degenerative disease. It could be consistent with a degenerative tear of the meniscus all the way to osteoarthritis.
Q. How does osteoarthritis lead to a popliteal cyst?
A. With the production of synovial fluid.
Q. By what mechanism?
A. One of the body's responses to mechanical irritation of the joint, the synovial fluid reacts by making additional fluid.
Q. How do you treat popliteal cysts if they haven't ruptured?
A. One, diagnosing the underlying cause, treating the underlying condition. If a popliteal cyst

is symptomatic in and of itself such that the patient, say, has difficulty flexing the knee, is quite uncomfortable, then on rare occasions I have aspirated these and on very rare occasions have excised them.
Q. By the way, are you giving any opinion about Dr. Wellman or just Dr. Posch?
A. I can give an opinion with respect to, I guess, either physician.
Q. If you have a popliteal cyst and it's not so symptomatic that the patient can't flex their knee, what do you do for them?
A. I'll try to determine the etiology, underlying etiology of the cyst.
Q. What do you do?
A. Do a physical examination, take a history, do some diagnostic testing.
Q. Which are?
A. Perhaps an X-ray, perhaps an MRI examination.
Q. What can you learn about a nonruptured popliteal cyst from an X-ray?
A. The X-ray will demonstrate signs of osteoarthritis.
Q. Anything else that it would be useful for with respect to the popliteal cyst?

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A That would be the primary role of the X-ray.
Q And when would you order an MRI?
A I would order an MRI scan if I -- if the information from that MRI scan was going to influence my treatment or to rule out some other source of swelling in the area, such as --
Q Such as?
A Synovial sarcoma, such as other types of soft tissue masses.
Q You wouldn't immediately proceed to an MRI, would you?
A No.
Q In most patients?
A No.
Q You'd see how they're responding --
A Uh-huh.
Q -- to conservative treatment?
A Right.
Q What is the typical conservative treatment for a nonhighly symptomatic, nonruptured popliteal cyst?
A I would -- if there was -- depending on my working diagnosis, if my working diagnosis was osteoarthritis, I would treat the patient

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accordingly with instruction with respect to activity level, with typically nonsteroidal anti-inflammatory drugs.
Q What would you tell them about their activity level?
A They may want to modify their activity a little if they've been particularly active and have inflamed their knee.
Q What kind of nonsteroidal anti-inflammatories would you have them take?
A Depends on the individual. Particularly if they did not have any significant GI history, I would start them off on something like Motrin.
Q Anything else?
A There's hundreds of them.
Q How about over-the-counter?
A Motrin is over-the-counter.
Q Let's say you think it's osteoarthritis, they've decreased their activity, they're taking their nonsteroidal anti-inflammatory drugs. How would you expect them to respond?
MS. REINKER: We're talking still about a nonruptured popliteal cyst?
MR. ROBERTS: Yes.
A They come back to my office, they're either

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going to be doing better or they're not.
Q Are there any other choices?
A Could be worse.
Q Okay. Let's talk about Dr. Wellman for a minute. He saw Mr. Rogers on October 12th, and he gave him an ultrasound. Would an ultrasound reveal a nonruptured popliteal cyst?
A Yes.
Q Would you see a bright white mass?
A Not on ultrasonography.
Q Okay. Would an ultrasound reveal a ruptured popliteal cyst?
A Probablynot.
Q Why not?
A Again, because you don't have a collection of fluid anymore. The fluid is dispersed.
Q When it's a ruptured popliteal cyst, would you consider the surrounding tissues to be compromised in any way?
A They would be edematous.
Q Why?
A Because of the extravasation of the fluid into those tissues.
Q Is there any compromise of the blood circulation in that immediate area?

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A No. The only injury to tissue would be the tissue that was torn when it ruptured. In other words, you break the bag, the part of the bag that tore sustained an injury. It tore. That synovial tissue tore.
Q And the fluid goes out into the surrounding tissues?
A Right.
Q Do you agree or disagree with Dr. Wellman's decision to prescribe a heating pad as opposed to ice or any other treatment?
A I don't object to it.
Q What do you usually do?
A Whatever is comfortable for the patient. Some people prefer ice, some people prefer heat. I'd advise elevation and rest, relative rest.
Q Isn't there a debate over ice versus heat as a first treatment for a swollen joint?
A There is -- this is -- we're not -- what we're trying to do is make the patient comfortable in this case. This isn't like -- you're not going to get cryotherapy to the area of injury. In other words, you can't cool down the area of the rupture. It's deep.
Q Is that what you'd do if you could? Is that

the best treatment?
A Itdepends.
Q In the best of all possible worlds, regardless of the patient's immediate comfort?
A Not necessarily. I mean it's a matter of comfort. Whether you use ice or heat, I think what we're trying to do is make the patient comfortable until typically Mother Nature heals this.
Q But doesn't it heal faster with one method versus the other?
A No.
MS. REINKER: "It" meaning what?
A No. If you -- I will use either ice or heat or a combination of both depending on what I'm trying to achieve. And in this case I think what you're trying to achieve is patient comfort.
Q I don't mean to be argumentative, but doctors don't always consider patient comfort above all other things, do they? You're saying in this situation --
A In this situation you're treating the patient's symptoms.
Q Because Mother Nature is going to heal the

situation?
A Right.
Q Does everything you just said apply to a ruptured popliteal cyst?
A Yes.
MS. REINKER: That's not what Dr. Wellman thought he was treating, just so that's clear. I mean -- because you asked him about Dr. Wellman prescribing a heating pad, and at that time he thought he was treating a contusion. That was before the diagnosis was made by Dr. Posch, just so that's clear.
Q Do you agree with Dr. Wellman's diagnosis of a contusion?
A That would be in the differential diagnosis.
Q Why?
A Because the patient, from my understanding, was in a kneeling position and may have been -- may have had excessive pressure on the area for an extended period of time.
Q Isn't a contusion usually associated with bruising?
A All depends on what's contused.
Q Well, here we're talking about his right leg, the upper lateral calf. Let's look at

Dr. Wellman's note of October 12th.
A Okay.
Q It has "Subjective" is that small handwriting, "Subjective right leg pain, three days of sitting cross-legged at a plumbing job, felt pain increased with walking out to truck, not had before. Tenderness is in upper outer calf. Pain is in same area. Swelling no help with Tylenol."
A Okay.
Q Is there anything to indicate that he had banged into anything, he had a bruise or contusion?
A He was sitting on it. He had his weight on it.
Q Sitting cross-legged. Did you read Mr. Rogers' deposition, talks about sitting Indian style?
A Uh-huh. That's what I pictured.
Q You picture him pressing his knee against the ground?
A Yes. He's at a job site, he's kneeling down, and his leg is in contact with the floor, his leg is in contact with tools, his leg is in contact with fixtures.
Q I kind of see him sitting, because he said he was sitting, he said he was sitting

cross-legged, and this says sitting. He was sitting. And sitting and kneeling are two different pressure points, aren't they?
A Yes.
Q What I'm trying to figure out is why, if he's sitting, his right knee would become contused.
A Again, picture I'm painting, if he was sitting, I don't think he would be contused.
Q Okay. Let's say Dr. Wellman believed it was contused. What do you do when you think one of your patients has a lower right contusion with swelling as you see it described here? Do you prescribe ice or heat or something different?
MS. REINKER: Objection. I think it's been answered.
A It depends on my assessment of it. I may prescribe either ice or heat depending on what I want to achieve, depending on what the patient tells me.
Q Is it significant that Mr. Rogers' right leg is four centimeters larger than his left?
A Yes.
Q Why?
A Because, one, it may indicate, assuming that the legs were the same circumference

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previously, you have evidence -- you have objective evidence of swelling, and I have something to measure with at subsequent visits.
Q Four centimeters is about 1.6 inches, right?
A Uh-huh.
Q Would you describe that as a fairly significant swelling?
A Yeah, I'd say that's a noticeable swelling.
Q Is that what you'd expect in someone who has a bruise on their knee, contusion on their knee?
A This isn't a bruise of the knee.
Q What do you think it is?
A This is a calf.
Q So your conclusion is he has a calf contusion with swelling?
A Yes. It's not my conclusion. I'm saying I'm trying to interpret what Dr. Wellman thought was going on.
Q Isn't that kind of swelling associated with a fairly traumatic injury, like a football injury?
A Or a muscle pull or --
Q Is there any indication he has a muscle pull in here?
A It's -- again, not having -- only having the

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note in front of me, it would be impossible for me to tell.
Q Let's say he doesn't have a muscle pull. What kind of trauma would you expect to cause this kind of swelling, this degree of swelling, what kind of contusion?
A I'd say there would be an injury enough that I'd expect to see in association with the swelling some tenderness.
Q Well, you've done a lot of sports medicine, haven't you?
A Uh-huh.
Q So you know what a football injury is?
A Right.
Q Did you ever play any football?
A Yes.
Q Did you play with Brian Dell by any chance?
A No. He was before my time.
Q Don't you think it would take quite a whack to cause your right calf to be one and a half inches wider or greater in circumference than the left?
A I'd say yeah.
Q Like getting a helmet in your calf or something?

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MS. REINKER: Objection.
A I'd say there would be some -- again, he's a plumber at a job site and --
Q He's fixing somebody's furnace in a trailer, sitting on the carpeting.
MS. REINKER: Objection.
MR. ROBERTS: That's his testimony.
A Okay.
MS. REINKER: This person has a furnace on carpeting? That's interesting.
MR. ROBERTS: He's sitting on the floor. It's not concrete. It's somebody's trailer.
A Dr. Wellman has a patient who has tenderness over the area, he has some swelling in the area and he has -- apparently this is the first time Dr. Wellman has seen the patient?
MS. REINKER: (Nodded)
MR. ROBERTS: Are you testifying?
Q He saw him sporadically over the years. He would fill in for Dr. Kakish.
MS. REINKER: How is that relevant to any of this?

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MR. ROBERTS: It's not my question. I'm answering his question.
A His evaluation, his diagnosis, his differential diagnosis included contusion.
Q Assuming you agree with that, and I'm not asking you to agree with it, do you agree that he should have prescribed heat?
MS. REINKER: Objection. It's been asked and answered a long time ago.
A Again, if it's going to make the patient comfortable. And in addition to this he had -- he recommended elevation as well. So if the patient is tender and has muscle -- he has muscle spasm or muscle pain associated with this, it would be reasonable.
Q All right. Do you take any precautions in your patients for whom you prescribe heat with a heating pad to determine whether they have any circulatory problems caused by diabetes or any other condition?
A Anytime I recommend heat, I instruct patients on the use of heat.
Q Do you give any different instruction to patients who have what you think might be a decreased nerve sensation in their legs?

A I give everybody pretty much the same instructions.
Q What is that?
A I would instruct them to make sure that the temperature is comfortable, and I use warm, moist heat in the form of a warm towel, which pretty much eliminates problems associated with exposure.
Q What keeps the towel warm?
A That's the point. They warm the towel up in the bathtub or sink and apply it, and when the heat is out of the towel, the treatment is over.
Q Do you know Dr. Posch?
A No.
Q Never met him?
A I may have met him.
Q Let's turn to Dr. Posch's note of the 15th of October.
A Okay.
Q Actually, why don't you turn to page 151 of the Mednet chart. Actually, it might be behind that.
A I don't have 151.
MS. REINKER: What is the

number?
MR. ROBERTS: It's that little call-in note, triage note.
MS. REINKER: What's the date?
MR. ROBERTS: 10-15-98.
MS. REINKER: I have to go backwards. There you go.
A I'm sorry, there it is.
Q Okay, it appears that on October 15th '98 there was a call made to Mednet asking for an increase in pain medication.
A That's not the note I have. The note I have reflects that the patient --
Q You'reright.
A The caller represents that the patient was taking Trisal and it's not helping. He's using heat. The question is what to do.
Q Let's go back to this Chol-Mag Trisal, 1000 milligrams. Is that a painkiller?
A It's an anti-inflammatory agent.
Q Did Dr. Wellman prescribe any painkillers on October 12th?
A He prescribed the Trilisate, which is an anti-inflammatory drug.
Q So he did not prescribe any painkillers?

A It has a -- I'm sure in addition to its anti-inflammatory function it has an analgesic function as well.
Q Okay. You don't disagree with that prescription for this patient?
A No.
Q All right. Let's look at Dr. Posch's note of October 15th '98.
A Okay.
MS. REINKER: He's looking at the typed one, the next page. There's two notes.
Q One of the things that was reported by Mr. Rogers on October 15th was that when he applied heat at home, it made his condition worse. And I think when he says his condition, he's describing the pain behind his right knee with difficulty extending the knee with associated swelling.
Do you have any opinion as to why that condition would be described as worse after application of heat?
A I believe that his symptoms may have gotten worse based on a couple things. First, I don't know if you've ever sustained any orthopedic

injuries.
Q Afew.
A As have I. When you first injure a tissue, your symptoms, as the body's healing response is mounted, your symptoms may get worse just as part of that.
In other words, you sprain your ankle, you're able to finish the basketball game, but the next morning and the day after that you're really quite sore.
So what we may be seeing is a natural history of his condition just developing.
Q Well, let's assume that he ruptured his popliteal cyst the previous Friday, October 9th.
A Okay.
Q And that he's been following his doctor's instructions, he's elevating his leg, he's taking his Trisal and applied heat. Typically, would you expect his condition to improve?
A How many days out are we now?
Q Now we're Friday to Thursday.
A So --
Q Injures it on Friday, sees the doctor on Monday, comes in on Thursday and complains of

the symptoms getting worse.
MR. ROBERTS: Did I get that right?
MS. REINKER: I'm sorry?
MR. ROBERTS: It is Thursday, right?
A I would think that that would be something that you'd want to explain.
Q All right. Would heat cause those symptoms to be worse in someone who ruptured a popliteal cyst the previous Friday, they elevated the leg, they're taking the Trisal?
A It's my opinion that application, the application of the heat, typically, if it were applied correctly, would basically not adversely affect it.
Q Do you think he sustained a burn from the heating pad here?
A Yes.
Q **A** third-degree burn?
A Yes.
Q Has there ever been a time when you've prescribed heating pads for your patients, not the warm towel?
A No.

Q Is there some reason why you prescribe the towel as opposed to the heating pad?
A Yes.
Q Why is that?
A I've had elderly patients, who seem to like the heating pads, burn themselves.
Q Some of your patients?
A Yes.
Q Early on in your career?
A I didn't prescribe the heating pad.
Q Okay. They went out and got one and put it on?
A Yes.
Q What kind of injuries did you see them sustain by the heating pad?
A Third-degree burns.
Q Were any of those patients diagnosed with diabetic neuropathy?
A No.
Q Do you think any of them had diabetic neuropathy at the time?
A I have no reason to believe it. It would be in an area -- one case I remember specifically, it was in an area where a diabetic neuropathy wouldn't be involved.
Q Any of them burn their lower extremities, knees

andbelow?
A I have no specific recollection of that.
Q What kind of burns do you remember?
A Low back.
Q How many times do you think you've seen that?
A Threetimes.
Q Any of them develop any infection?
A No.
Q When they presented to you, did they already have the third-degree burn and you found out about it, saw it?
A They came to me for treatment of their back. They had already had the treatment for the burn.
Q Do you treat burn injuries?
A Not typically.
Q Other than in an emergency, who would you turn to to treat a burn injury?
A I would typically refer to a plastic surgeon.
Q What if you had some concern there might be infection, who would you call in on that?
A Again, I would refer, if I had a bum, a significant burn, I would refer that to a plastic surgeon.
Q Would you ask for an infectious disease

consult?
A Basically, when I refer to the plastic surgeon, I back away from the care.
Q And let the plastic surgeon determine whether he needs an ID consult?
A That's correct.
Q Would you describe the burn and necrosis that Mr. Rogers had here as a significant burn?
A From what I understand, when Dr. Posch first saw this, he thought he had a partial thickness injury, some erythema associated with the overuse of the heating pad.
Subsequent examination, Dr. Posch made the diagnosis of a full thickness injury to a part of the area that was exposed, about the area the size of a quarter.
Q That's the third-degree area?
A That's the third-degree area.
Q Surrounded by a bigger second-degree area?
A Right.
Q Which was eight centimeters, 3.2 inches?
A Yes. Depends on the individual practitioner's comfort level. Would I be comfortable treating that injury at that point in time? Yes.
Q Youwould?

A Yes.
Q You wouldn't refer that out or call in a consult?
A No.
Q Okay. Let's go back to the 15th here. Dr. Posch didn't take a temperature that day, did he?
A Not that I'm aware of.
Q Do you think that on October 15th Dr. Posch should have considered infection as a potential cause of the symptoms he observed and were reported to him?
A Not at that point in time.
Q Were any of the symptoms that were reported to him or anything he examined and found consistent with infection? I'm talking about October 15th.
A No.
Q Isn't swelling consistent with infection? I'm not saying it's diagnostic of it. I'm saying it's potentially diagnostic. Right?
A He had a good explanation for the swelling.
Q I understand. But swelling can be consistent with infection.
A Yes.

Q Socanerythema.
A Again, he had a good explanation of the erythema.
Q But erythema can be consistent with infection?
A Yes.
Q So can acute tenderness, correct?
A Yes.
Q Wouldn't you agree there are certain signs here that are inconsistent with the normal course of a ruptured popliteal cyst almost a week later: Somebody has put up their leg, they've been using Trisal, they've been using heat, they've been basically inactive, presents on the outside of the knee.

And you and I can disagree about whether it presented acutely or not, but forgetting that, aren't there certain things here that are inconsistent with the typical course of a ruptured popliteal cyst?
A He doesn't have just a popliteal cyst rupture. He sustained a burn.
Q Okay. Is there any potential for infection here? Somebody has a burn, they're a diabetic, he's postcoronary bypass, he's got coronary artery disease, he's 57 years old. Isn't he

more likely to get an infection than a typically healthy person?
A Yes, he is.
Q Dr. Posch didn't prescribe any antibiotics that day. Do you have any fault with that?
A Not at all. I don't think he's infected on the 15th.
Q You think he became infected at some point?
A Obviously.
Q Yes. When do you think he became infected?
A I think he became infected sometime between the 23rd and the 26th.
Q And what would you say is the cause of the infection? What happened?
A I think that he has a traumatized extremity. The tissue has been traumatized by mechanical injury.
Q The ruptured cyst?
A The ruptured cyst. There's some edema. He then sustains an injury to the dermis and the protective function of that dermis has been compromised, and he seeds this compromised tissue with bacteria and has an infection develop.
Q Would the fact that he was diabetic cause that

infection to be more likely to develop?
A Yes.
Q Why?
A You have a compromised host, you have problems with vascularity, you have problems with the immune system, you have problems with nutrition.
Q Would the fact that he is a postcoronary bypass patient increase his likelihood of infection in that extremity?
A I'm not aware of his peripheral vascular status.
Q Have you treated necrotizing fasciitis?
A Yes.
Q Has it ever developed in any of your patients under your care?
A No.
Q How many times have you seen it in the lower extremity?
A Perhaps three or four times.
Q How about total?
A Three or four times.
Q Does it typically develop in the lower extremity?
A Yes. Well, there's -- I can't say that for

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certain in that there's a certain population of patients, such as intravenous drug users, who develop this infection from infected needles and poor care in the upper extremity.
Q That group doesn't apply here, does it?
A Okay. No, it does not.
Q All right. Have you ever actually seen somebody with necrotizing fasciitis in the upper extremity? I think you already answered that.
A No.
Q Other than that IV needle user group, the more typical presentation is in the lower extremity, right?
A Yes, but also in the trunk and abdomen.
Q And aren't diabetics more likely to get necrotizing fasciitis than the population as a whole?
A Yes.
Q Do you recall what strains of bacteria were the cause of the necrotizing fasciitis you treated?
A I believe mine was a mixed infection.
Q Is that true in every one, all three or four you had?
A I can't remember the bacteria associated with

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these.
Q In those cases, who made the diagnosis of necrotizing fasciitis? Was that you or somebody else?
A I did.
Q Are these patients you saw in your clinical practice, or are they in the hospital or some mixture or both?
A They were in the hospital.
Q Were you managing the treatment of that necrotizing fasciitis?
A Yes.
Q What did you do?
A I took a guy's leg off at the hip.
Q How about the other ones?
A Those were during my training. That also resulted in an amputation, actually a hemicorporectomy.
Q Being what, just what it sounds like?
A Yes.
Q Half your body is cut off?
A Yes.
Q So he had it in both legs?
A Yes.
Q Was this at the Clinic?

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A No.
Q Where was this?
A That was at Parkland Hospital in Dallas, Texas.
Q The case that you did manage I assume was too far gone to be cured with antibiotics?
A Yes.
Q That's why you amputated?
A Yes.
Q Did you also prescribe antibiotics?
A That was managed by an infectious disease expert.
Q Is that someone you called in?
A Yes.
Q Was that here in Cleveland?
A Yes.
Q Which hospital?
A St. Vincent's Charity Hospital.
Q Which text do you rely on in orthopedics? What do you consider authoritative?
A I don't really refer to texts much.
Q Did you ever?
A During my training.
Q If someone said to you what's the bible of orthopedics, what would you say?
MS. REINKER: Objection.

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A By the time -- I've written textbooks, you know, and by the time the information is in the textbook, it's pretty old, so -- I would tell my residents to read -- I think they need to understand what's gone on before, and I think Campbell's would be an appropriate textbook to read for someone in training.
Q Okay. Anything else?
A There's all sorts of good textbooks.
Q How about Chapman's book on operative orthopedics?
A I don't think I've read that.
Q No? Okay. Let's go back again to October 15th. Nothing was prescribed for this burn, was it?
MS. REINKER: On the 15th?
MR. ROBERTS: On the 15th by Dr. Posch.
A From a medication standpoint?
Q Yes.
A He was given some -- the patient was given a prescription for some Vicodin for the discomfort associated with it.
Q Basically, he was prescribed an Ace bandage, ice, crutches, elevation and Vicodin?

A Right.
Q Right. There's been some testimony that Mr. Rogers was applying Neosporin to his burn over the period of time from October 15th to October 21st. If Dr. Posch had prescribed that, do you have any opinion as to whether that was appropriate or inappropriate?
A I'd say it was appropriate.
Q Is it appropriate to apply Neosporin to broken Skin?
A I think it's appropriate to apply Neosporin to things such as an abrasion.
Q What about this, this burn, this third-degree burn?
MS. REINKER: You're asking if it was appropriate? I think he just said it was.
MR. ROBERTS: I think he said it's appropriate for an abrasion, not a third-degree burn.
A I think it's appropriate in this case to apply that.
Q Well, he stopped using the heat presumably on the 15th when Dr. Posch told him to stop and to use ice, right?

A Right.
Q I don't think there's any evidence to the contrary.
A Right.
Q So by the 15th he had a third-degree bum of his leg, right?
A Right.
Q And it progressed to the condition described on the 21st, right?
A On the 15th he did not have a third-degree burn.
Q Okay. Tell me how it progresses without any further application of heat from what's described on the 15th to what we see on the 21st.
A The tissue has been damaged by the heat, and it's not uncommon that you see an injury after a thermal -- you see a thermal injury, and the extent of that injury does not declare itself for some time after, for perhaps five days, a week or so, because the injury is ongoing.
You know that once you remove your hand from the hotplate, the tissue damage continues. You get out of the sun, you're a little bit red that night, the next morning you

have a blistered back. The tissue is undergoing further damage, and that's what's going on here.
When he saw him on the 15th, there was no evidence of a third-degree skin loss at that point in time, and I believe Dr. Posch states that there was a change between the 15th and the 21st and that he was chagrined to see this change.
Q Right. That's in his deposition, right?
A Yes, and it's reflected in his notes.
Q Should Dr. Posch have given Mr. Rogers any instruction as to what to look for in the condition of this burn, say if it was progressing, getting worse, he should call back, if it blistered, the blister popped?
A I believe he did that. On the 15th the last thing in his note is, "He is to follow up in a week for recheck and is to call sooner if he has any problems."
Q Okay. So he comes back on the 21st. Let's talk about the 21st.
A Okay.
Q By the 21st we now have somebody whose leg, I would assume, was traumatically injured on the

9th, has now been elevated for 12 days and has had heat, has had ice, has had nonactivity, and yet his description of the pain in his deposition was it was absolutely unbelievable, couldn't bend his knee, the swelling is at least the same if not worse.
Is that consistent with the normal course of a ruptured popliteal cyst?
A Again, he has more than a ruptured popliteal cyst. He has a burn on top of it.
Q You think all his stiffness in his knee and the swelling is attributable to his burn now?
MS. REINKER: Objection.
A I think both things are cumulative in his case.
Q Do you think there are any signs or symptoms of infection on the 21st of October at all?
A There aren't -- I don't believe his leg is infected on the 21st.
Q Wouldn't you agree that any open wound is infected?
A He doesn't have an open wound.
Q Isn't it described by Dr. Posch as weeping and open?
A No.
Q Did he describe it that way in his deposition?

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A I read Dr. Posch's deposition, and there was a lot of discussion about -- I read his note, and let's start with the note first. He describes the area as an area of necrosis, third-degree necrosis about the size of a quarter in an area of surrounding erythema.

In his deposition he described the same lesion, and then there was discussions with respect to hypothetical cases with respect to blisters and second-degree burns and these things. And it's my interpretation of the deposition that what Dr. Posch's -- throughout that deposition on several occasions he came back to his original description of the skin lesion as being an area four by eight centimeters of erythema with a central area of third-degree necrosis.

And his impression at the time of his note was that this was a healing -- in other words, the burn had finally demarcated itself. It doesn't appear that the area of injury was getting any bigger, and we know that we're dealing now with a third-degree loss in the central area of this burn.

Q Okay. I want to hand you Dr. Posch's

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deposition from your own set of records provided you in this case. Look at page 39, please.

A Okay.

Q This is when I asked him to describe what he saw on the 21st.

A Okay.

Q And the beginning of page 39 I asked the question. He said, "I remember when I first saw him on the 21st I was rather taken aback that he had this area of full thickness necrosis."

I asked him why. He said, "Well, I was hoping when I saw him the previous time, on the 15th, that the area of erythema would be clearing up. Instead, it was getting worse."

"Okay. Just for the record, what do you mean by full thickness necrosis?

"Answer: Like I said, he has an area of four by eight centimeter central --" you can read along with me.

A Right.

Q I said, "So the skin was there, but it was dead?

"Answer: It was dead and surrounded

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by the second-degree burned area, which was weeping and open consistent with a blister that had gone on to necrosis."

If a wound is weeping and open, then it's not a dry eschar, is it?

A I'd have to say that he -- his second sentence, okay, he's talking about a second-degree burn, and he's talking about necrosis. And he must have misspoke because on other occasions -- because second-degree and necrosis aren't used -- they can't pertain to the same thing, so he misspoke in that second sentence.

And I think a more accurate description -- okay, when was the deposition relative to his -- to the treatment of the patient? **A** more accurate description is what he wrote in his own hand at the time of treating the patient.

Q Would you agree I didn't put any words in his mouth in that answer?

A I would agree that he was answering a lot of questions in rapid succession.

Q That's what a deposition is.

A I understand that.

Q It wasn't necessarily rapid succession, was it?

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You weren't there.

A I could say that I have on occasion misspoke.

Q Okay. Dr. Posch went to Yale Medical School. He's familiar with medical terminology, he's a highly educated man, he's board certified. I didn't make him say that, did I? I didn't trick him into it?

A No, you didn't.

MS. REINKER: He wasn't there. How does he know if you tricked him into it?

Q Is it your opinion I tricked him into saying these words?

MS. REINKER: Can I give my opinion?

MR. ROBERTS: No, you can't.

A I would expect people to answer to the best of their abilities. And we're all human, and we do make errors in our use of language.

Q Well, if this wound was weeping and open, would that tend to indicate to you that it was actively infected?

A No.

Q Why not?

A I've had blistering sunburns that were weeping and open, and they weren't infected.

Q You say infected. You mean actively infected?
A Yes, infected. In other words, you have bacteria on your skin all the time. It's when you have -- when that bacteria is producing a toxic effect that we would have infection.
Q Everyone's skin has bacteria on it, right?
A Right.
Q When you have a break in your skin, don't you presume there's infection?
A No.
Q You presume there's colonization?
A I've treated in my -- I've treated many open wounds, and these wounds are certainly colonized with bacteria, and they're not infected.
Q What do you do to prevent infection in patients with open wounds?
A Leave them open.
MS. REINKER: When you're at an appropriate time, I want to get some more water.
MR. ROBERTS: That's fine.
(Pause)
Q Doctor, you just described how you leave open wounds open. Would you cover that wound with

an Ace bandage and Neosporin to help prevent infection?
A You asked me a question about colonized wounds, and I was giving you an example of an open wound that we'd allow to heal by secondary intentions. I wasn't speaking to this wound.
Q What do you mean by secondary intention?
A In other words, if I have someone who sustains serious contaminated injury to their tibia and I have debris and grass and --
Q Motorcycle accident?
A Yes. -- in the wound, I will debride the wound, and I may allow the wound to remain open.
Q That's a patient who is admitted to the hospital?
A Yes.
Q They're not at home.
A I have treated patients who have had infected orthopedic hardware in association with surgery of the spine with wounds from the nape of their neck to their pelvis, open, treated with applications of Betadine and sugar at home, without IV antibiotics or any oral antibiotics.
Q Well, sugar is one of those old-fashioned

remedies, isn't it, for a wound healing?
A Yes.
Q Okay. But in those patients --
A You can have an open wound that is colonized with bacteria but the patient is not infected.
Q All right. Were any of those patients diabetic?
A Yes.
Q Any of those patients have no nursing care at home?
A They have a spouse.
Q But those patients, the situation you just described where they have an open wound from the nape of their neck down to their tailbone, you don't send them home with just their spouse and no follow-up instructions, do you, no nursing care at all?
A They're taught how to do the dressings while they're in the hospital, and they're discharged to home, and if their spouse can handle it, their spouse does it.
Q What are they taught to do with the dressings?
A They'll apply the --
Q Betadine?
A The Betadine and the sugar, and a dressing is

applied, and they change it when -- you know, on a daily basis.
Q What does the Betadine do?
A Betadine is an antiseptic.
Q Can you use to it treat infection?
A It's a topical -- iodine is a topical antiseptic. We wash our hands with it before surgery.
Q What does the sugar do?
A The sugar provides -- it dries the wound out some, helps remove exudate. Because of that you can have a high enough concentration of sugar that bacteria have a hard time living in it.
Q No sugar is prescribed here for --
A No, he doesn't have --
Q -- Jack Rogers.
A It's not the same wound.
Q It's not an open wound?
A No.
Q Because why?
A Because he has -- this is a burn. It has an area of second-degree burn and an area of third-degree burn in the center of it.
Q Wouldn't you agree necrotic skin has no

resistance to infection?
A Yes.
Q So you don't disagree with the prescription of an Ace bandage with Neosporin over this necrotic wound, this burn?
A Not at this point in time, not on the 21st.
Q At what point in time would you disagree with that application?
A I would disagree with the application if I had an unstable eschar.
Q Which is what?
A When that central area of necrosis is no longer intact.
Q How would you know if it's intact or not?
A By examination of the wound.
Q What does weeping mean?
A Just that, weeping, like a sunburn or an abrasion. If you skin your knee, there's weeping of this fluid.
Q It's like a layer of fluid?
A Yes.
Q All right. I take it you disagree that he should have had the wound debrided on the 21st?
A I think -- I don't think there was an indication to debride the wound on the 21st.

Q How about on the 23rd, was there an indication then?
A I don't know what the leg looked like on the 23rd.
Q Does the MRI help you?
A Not really.
Q Do you think that MRI should have been done on a stat basis?
A No.
Q Let me ask you this. Do you think that, you know, the description here is a healing thermal bum, and, you know, you've said that Dr. Posch misspoke about it being weeping and open, so if it was a dry eschar, it's a healing thermal burn, is it still the cause of all this pain and stiffness in his knee?
MS. REINKER: Objection. I don't think he ever said it was the cause of all the pain.
MR. ROBERTS: I'm asking.
A I think he has two things going on that are causing pain and stiffness in his knee: One, he has an underlying arthritic condition, okay, which started all this; number two, he has a ruptured popliteal cyst, and this has been

complicated by a thermal injury.
Q Is his arthritis kind of bothering him? If he's keeping his leg up for 12 days, is that causing pain and stiffness and swelling?
A No, not at that point in time.
Q All right. In fact, there have been no actual diagnoses of arthritis until October 9th -- sorry, October 8th. Dr. Kakish says right hip and knee pain probably secondary to degenerative arthritis.
A Right.
Q The MRI didn't talk about degenerative arthritis, did it?
A I don't have a -- I haven't -- I don't remember verbatim the report.
Q There's a page 306. These are not necessarily in order.
A I can read yours.
MS. REINKER: Here's my copy.
The report does not describe an internal derangement of the knee.
Q What else is going on on the 21st? You said ruptured popliteal cyst. You're thinking arthritis?
A Andtheburn.

Q After looking at the MRI and my discussion about the record on October 8th, do you still think he had arthritis on the 21st?
A No. That's why the MRI scan was done, to help explain the patient's persistent symptoms.
Q Okay. Well, is the fact that he didn't have arthritis on the 23rd helpful in determining whether he did have a ruptured popliteal cyst?
MS. REINKER: Objection. I don't think we know if he had arthritis on the 23rd. The MRI doesn't comment on it.
A The MRI does not comment, you're right, with respect to arthritis.
MS. REINKER: Bone structure.
A Unfortunately, we don't have an MRI examination on the 8th.
Q Well, you would expect a radiologist on the 23rd to note any arthritis of the knee, wouldn't you?
MS. REINKER: Objection. I'm sorry, I'm just objecting because it looks -- well, objection.
A I can't comment on what the radiologist would or would not report.
Q Well, I think -- can you agree that the

University Hospital of Cleveland has a pretty good radiology department?

MS. WINKER: Objection. They weren't looking for that, Kevin.

MR. ROBERTS: I'm asking a question. All right?

MS. REINKER: Okay.

A I have no experience with that radiology department.

Q All right. Fair enough. Let's say this radiologist is right and there is no arthritis. Okay?

MR. ROBERTS: You can object for the record. Okay?

MS. REINKER: Object.

Q Let's say there's no arthritis on the 23rd. Let's assume that. Okay?

MS. REINKER: Let's pretend.

A The radiologist states that there was no meniscal pathology on this MRI examination.

Q I think you said that you thought if he had a ruptured popliteal cyst, that a probable cause is osteoarthritis of the right knee. Okay?

A That's a common cause of it.

Q If as of the 23rd that potential diagnosis of

the 8th has been ruled out by this MRI, does it make it less likely that there was a ruptured popliteal cyst as of the 23rd?

A No.

Q What would be the cause, then, if it wasn't osteoarthritis?

A You can have them develop just de novo. You can have popliteal cysts that are not in our knees. They are in and of themselves. They are not secondary to any other pathology.

Q Isn't that kind of rare?

A It's not the most common presentation, you're right.

Q Is there anything about his presentation of a ruptured popliteal cyst that is on the common side of the equation?

A I think his presentation with that of an injury to the knee occurred while flexing the joint is consistent with it. I think his tenderness and ecchymosis that was noted is consistent with it.

Q But not the location of it, right, out on the lateral side on the calf!

A He had calf tenderness. The thermal injury, it's my understanding, was lateral.

Q But his original description of pain is lateral, isn't it, on the 12th?

A Posterior. It's calf pain.

Q I'm looking at Dr. Wellman on the 12th. "Leg pain not had before. Tenderness is in upper outer calf." Right?

A Okay.

Q That's where he told him to put the heating pad, and that's where he did, and that's where he got the burn. Put the heating pad where it hurts, right, does that make sense?

A Uh-huh.

Q So that upper outer calf is not the typical place of swelling for a ruptured popliteal cyst?

A That's true.

Q So other than the assumption that he hurt it while flexing his knee on the 9th, is there anything else that's typical of this presentation of popliteal cyst?

A The swelling, the posterior location of it, the history of flexion, and then we have the complicating issue with respect to the thermal injury, so I can't say that I've treated a popliteal cyst where the leg has been

traumatized with a burn as well. So that in and of itself is atypical.

Q Does it tend to throw you off the path of a normal diagnosis?

A I think that's why Dr. Posch -- Dr. Posch recognized that it wasn't typical, and for that reason he recommended an MRI examination.

Q The MRI also revealed potential for infection, right?

A As part of the differential diagnosis, yes.

Q Didn't Dr. Posch describe a fluctuant mass on the 21st?

A Yes.

Q And can't that fluctuant mass also be consistent with infection?

MS. REINKER: Objection.

A It means a soft, an area of soft fluid collection.

Q I understand. But couldn't it also -- it could be from several causes, right?

A Right.

Q One of them could be infection?

A Yes.

Q As of the 21st, you have a patient who is diabetic, they're postcoronary, they have a

very abnormal presentation of ruptured cyst, right?

MS. REINKER: Objection.

Q They have a damaged tissue, they have a fluctuant mass, they have an area of full thickness necrosis, and if it's weeping and open, is there any reason under all those circumstances to suspect or safeguard against infection?

MS. REINKER: Objection. How can he answer that?

Q In the lower extremity?

MS. REINKER: Objection. Wait, wait. You have misconstrued the facts. You have asked him three questions rolled into one, you have made some statements that he's already testified are not correct, and I'm not going to let him answer it the way it's asked.

MR. ROBERTS: You're not going to let him answer it?

MS. REINKER: Not the way it's phrased. If you want to rephrase it and correct the record. He said it's not an atypical presentation of a popliteal cyst, and you put in your question it's an unusual

presentation, and that's not correct.

MR. ROBERTS: All the factors for ruptured popliteal cyst, there are only one or two that are normal.

MS. REINKER: He listed five or six that are normal.

MR. ROBERTS: He didn't say five or six.

MS. REINKER: We needn't recite that but --

MR. ROBERTS: Let's get it straight. This is very important.

MS. REINKER: All right.

Q The cyst didn't present, there's no evidence of an outpouching, right?

MS. REINKER: Objection.

MR. ROBERTS: We already went over this. Didn't we say this before earlier in the deposition?

MS. REINKER: No, no, no.

Q There's no record?

A Norecord.

Q No record of an outpouching, okay.

MS. REINKER Which may or may not be -- that's not typical. I mean that's --

MR. ROBERTS: Can I ask him a question, please? We can argue later. You can argue to the jury.

Q Is there any record of an outpouching before a rupture?

A There's no record of it.

Q Okay. The swelling is on the upper outer calf!

A That's correct.

Q Which is not the usual presentation?

MS. REINKER: Objection. That was only on one occasion. That's where Dr. Wellman noted something, but everywhere else in the record talks about popliteal swelling. If you want to take that one visit out of context, go right ahead.

MR. ROBERTS: Show me where it says popliteal swelling.

MS. REINKER: I'm looking at Dr. Posch's note on the 15th, swelling and tenderness upon area and lateral aspect of the right proximal leg.

Q The initial presentation is described as upper outer calf. Would you agree that is not the typical presentation for a ruptured popliteal cyst?

MS. REINKER: Again, that's --

MR. ROBERTS: Let him answer the question, please.

MS. REINKER: That's where it says the tenderness is. It doesn't say that's where the swelling is. The swelling involves the whole calf, apparently.

MR. ROBERTS: Apparently why?

MS. REINKER: I don't know. It just says tenderness is in upper outer calf. It doesn't say where the swelling is, doesn't limit the swelling to that area.

Q Wouldn't you expect the swelling to be where the tenderness is, Doctor?

MS. REINKER: Objection.

Q For a contusion or a ruptured popliteal cyst, that it would hurt where it's swelling? That's where the damaged tissue is?

A I don't think you can make -- in the case of contusion, yes. With respect to -- if you have a popliteal cyst that ruptures and you have a lateral popliteal cyst that ruptures, it doesn't -- because it's lateral doesn't mean that you didn't have a popliteal cyst.

Q I'm not saying it is. I'm asking about at this

point, I call it in the area of swelling. We're kind of going off track a little bit.

A All I'm saying is that popliteal cysts occur more commonly medially.

Q Since we're arguing about this, let's look at Dr. Wellman's note of October 12th. There's objective signs. He says, "Right leg tenderness in the upper lateral calf secondary to swelling and edema."

Wouldn't you read those two together to mean that the swelling and edema is in the upper lateral calf if you're reading this chart for the first time?

MS. REINKER: You're talking about secondary to swelling. I don't know what you're --

MR. ROBERTS: He can answer.

MS. REINKER: It's not in the record what you just said. It just says positive swelling.

MR. ROBERTS: Doesn't it say 2 plus?

MS. REINKER: No. It says positive. It has a little positive mark in a circle.

Q Is that a 2?

A No. That's a plus sign with a circle around it.

Q What's to the left of that? What's that?

A "Swelling."

MS. REINKER: That's the link.

A It's a plus sign with a circle. Then it says "swelling" after that.

MS. REINKER: Let's look at your copy, if you want to give him that page, or do we have an exhibit?

(Document handed to witness)

MR. ROBERTS: There.

MS. REINKER: You're looking down -- okay.

MR. ROBERTS: Under "objective."

MS. REINKER: You're looking at a different part.

A "2 plus swelling, moderate."

Q If you read this chart for the first time, where would you think the swelling was, based on how doctors chart their patients?

MS. REINKER: In the right leg.

A I'd say --

MR. ROBERTS: Will you stop

answering for him.

MS. REINKER: I'm sorry. You're taking stuff out of context.

MR. ROBERTS: Susan, you can register your objection to the form without telling him how to answer.

MS. REINJSER: Okay. Objection.

MR. ROBERTS: He's a board certified surgeon. He can answer the question. You don't have to answer for him.

MS. REINKER: Thank you for sharing.

MR. ROBERTS: You're welcome.

A It's my impression reading his note that he was describing tenderness over the proximal lateral aspect of the calf and swelling of the calf. Swelling in those sorts of soft tissues really isn't localized.

Q Allright.

A It just isn't. Go ahead.

Q If the swelling is in the upper outer calf, if, okay, and the tenderness is in the same place -- by the way, didn't Jack Rogers describe it as being swollen in the upper outer calf'? Do you remember that?

A Most of what I remember from Jack Rogers' deposition is that he had a hard time remembering the events about that time.

Q I think he was asked to make little marks on a drawing of a leg as to where he had wounds and swelling and so forth. My recollection is it's all in the upper outer calf. All right. Let's go back to the 21st.

A Okay.

Q Is it your testimony that, given everything we've talked about and what you've seen here, that there is no indication that Dr. Posch should have suspected infection in any way, shape or form, shouldn't have even put it in a differential diagnosis or considered it?

A At that point in time, with what he saw and reflected in his notes is that he thought he had a burn that had demarcated itself, had declared itself to its extent, and he had posterior knee pain, persistent posterior knee pain, and he at that point in time wished to pursue the diagnosis further with additional testing, that being an MRI examination.

At that point in time there was not clinical evidence that was consistent with

infection.
Q. If you attribute the erythema to a burn, the swelling to the cyst, the failure of his pain to subside to what?
A. To the damage caused by the combination of both of those things.
Q. Why would a healing thermal burn cause pain if you're not moving your leg, if you have a scab, a dry eschar?
A. He has an area of erythema associated with that. The tissue has been damaged. He has swollen tissue that's been damaged by mechanical injury and by thermal injury.
Q. Which means it's more susceptible to infection, right?
A. Damaged tissue is more susceptible to infection.
Q. Right. You have a fluctuant mass which you can see on the MRI, but he palpated that on the 21st. He's got a large open area on the skin adjacent --
A. Hold on. You said there was a fluctuant mass that was seen on the MRI?
Q. Isn't there an area described as an abnormal fluid collection, diffuse as well as focal, in

the subcutaneous and deep tissues in the subcutaneous --
A. If he has -- you're talking about -- he's not talking about -- when you say a fluctuant mass, that would be described differently in an MRI report.
Q. Okay. Well, let's go back to the 21st. Dr. Posch describes in the right popliteal area right leg with palpable fluctuants, aspiration was attempted.
A. Right.
Q. So he has a palpable fluctuant behind his knee, he has an open wound, he's diabetic, he's got continuous pain and swelling, and he's got an Ace bandage and Neosporin on it. Wouldn't you have any suspicion whatsoever for infection?
A. Dr. Posch is the person who is examining the wound, and the diagnosis is based on -- it's based on your clinical examination at that point in time.
And he saw this wound evolve over time. He's watching it. He saw it five days earlier. He's seeing it now. At this point in time the wound in -- he was chagrined to see that what was second degree had now declared

itself to be third degree. That's something that needed to be dealt with. And this guy has continued posterior pain, and he's going to continue to explore that, but at that point in time he did not have an infected leg.
Q. That's not my question. My question is, given everything he saw at the time and knew at the time about this patient, everything that's in the chart, should he have no suspicion for infection, never?
A. I can't comment as to what suspicions he had.
Q. I'm not asking you to. I'm asking what would a reasonably prudent physician presented with this patient who has diabetes, an open wound, who has damaged tissue, who has palpable fluctuants and has an Ace bandage with Neosporin over this wound and is sent home, wouldn't you think there would be any suspicion of infection in that patient?
MS. REJNKER: Objection. That's just been answered.
A. It's my impression -- it's my -- I'm sure Dr. Posch was vigilant with respect to signs of infection.
Q. Well, I'm not asking for a subjective answer

about what you thought Dr. Posch was thinking. I'm asking what objectively in the medical profession one would expect under all these conditions.
A. I wouldexpect --
Q. Pretend there's no lawsuit. It's not Dr. Posch.
A. It doesn't make any difference to me whether there's a lawsuit or not. At this point in time, Dr. Posch, his impression was that he had a ruptured popliteal cyst, okay, that he could explain the patient's posterior calf pain with -- he had a thermal injury that contributed to this patient's pain, but the thermal injury appeared to be at this point in time stable.
The fluctuant is, at this point in time Dr. Posch thought was secondary to his ruptured popliteal cyst and a collection of hematoma. He investigated that with an attempted aspiration and was not successful in withdrawing any fluid.
Q. What's the hematoma from?
A. From the tear of the tissue associated with the ruptured cyst.

Q Well, the 21st is 12 days after the date you're assuming is the rupture, on the 9th.
A Right.
Q And there's no evidence of active osteoarthritis in the MRI?
A Right.
Q He's not using his leg?
MS. REINKER: Objection.
Q Why would he tend to produce synovial fluid?
A I didn't say synovial fluid.
Q Why wouldn't the synovial fluid extravasate itself into the tissue?
A He had ecchymosis. When you tear something, if you tear a cruciate ligament in your knee, you're going to have some blood that goes into your knee, a certain amount of volume of blood, 50 cc's of blood. You are not -- you're putting your leg at rest.
The joint will continue to swell, not because of continuing mechanical injury, but because that blood associated with the injury as it rises draws blood to it, and that's what we see in mechanical injuries. There's damage to the tissue, there's bleeding associated with that damage, and that blood will continue to

draw fluid to it and actually will expand over time. That was the intent of his aspiration.
Q Well, apparently he only aspirated a few drops of blood.
A It's not uncommon.
Q Is that surprising?
A It's not uncommon. Most attempts at aspiration are, excepting like an obvious effusion in the joint, are not very successful.
Q So are you saying there palpable fluctuants on the 21st is from the tear on the 9th?
A Yes.
Q It's not synovial fluid; it's blood attracting other fluids?
A It's a combination of both, but it's more likely, more likely blood that draws more additional fluid into the space.
Q What kind of fluid does it draw in?
A Interstitial fluid.
Q Back to my question. I mean we have somebody with an open wound next to this palpable fluctuants --
A No, it's not an open wound.
Q If it's weeping and open, is it not an open wound? If that description is correct, that

it's weeping and open and it's over the area of palpable fluctuants and it's colonized, isn't that more susceptible to infection than a dry wound?
MS. REINKER: Wait. Objection again to your statements.
MR. ROBERTS: If.
MS. REINKER: But if there was an open weeping area, it was nowhere near the fluctuants -- well -- *sorry.* It's been the testimony so far, if such a thing occurred.
A It's my understanding that the fluctuants was posterior and the needle aspiration was done in the posterior aspect of the calf. It's my understanding that the area of full thickness necrosis was in the lateral aspect of the calf. That's the area of the burn. The --
MS. REINKER: Okay.
A And it's my impression that he does not -- Dr. Posch's handwritten note demonstrates that his impression was that of a healing burn at that point in time.
Q My question is, if it's weeping and open, isn't it an open wound? Right? Don't those words mean that, it's an open wound if it's weeping

and open?
A I don't know what open means in this case. I don't know what -- an open wound to me means there is separation of the skin.
Q Well, third-degree necrosis -- third-degree burn means full thickness burn of the skin, right?
A Right.
Q Which is a hole in your skin?
A No.
Q Theskinisgone?
A The eschar is intact.
Q But not if it's weeping and open?
MS. REINKER: Objection.
Q Okay. Forget it. We're not going to get anywhere on this.
A I don't --
MS. WINKER: That's okay.
A I don't see the wound as being -- the wound is not open. As far as my impression of the wound, it is not open at this point in time.
Q So you're disagreeing with the surgeon who saw it and described it as weeping and open?
MS. WINKER: Objection.
Q You are, right?

MS. REINKER: No, he's --
MR. ROBERTS: Let him fiiish.
A I'm agreeing with the surgeon's note at the time of his examination of the patient.
Q But you're disagreeing with his sworn testimony?
MS. REINKER: Objection.
A I don't know -- all I'm saying, I don't know --
Q Let's keep going.
A -- what Dr. Posch's definition of open is.
MS. REINKER: We've already been at this for two hours, and I think you said about an hour ago you were going to be about another half an hour.
MR. ROBERTS: I'm sorry. We have constant interjection and semantic arguments.
MS. KEINKER: No, we don't.
Q He's described the patient as very thirsty. Is that an indication of infection, among other things?
A It's an indication that he was alert to take a history from the patient and recognized that the thirst may represent that his diabetes is not in the best control.

Q Have you ever had a patient who was diabetic?
A Yes.
Q Have you ever had a patient whose diabetes was out of control due to infection?
A Yes.
Q He has a blood sugar level on that day of 375. Would you describe that as out of control?
A Yes.
Q No matter what time of day it was taken?
MS. REINKER: Objection.
A I don't know what he ate immediately before that.
Q Well, he's been at the doctor's office for a while, I presume, being examined?
A I'm not a diabetologist. I'm not a diabetologist.
Q Would you describe 375 as out of control?
MS. REINKER: Objection.
A If I had a patient with 375 blood sugar, I would ask him to call his diabetologist.
Q Do you intend to do any further investigation in this case, any further opinions?
A No.
Q Let me ask you this. If he had been admitted on the 21st and there had been a debridement,

would that have been some form of malpractice?
A No.
Q Why not?
MS. REINKER: Objection.
A It's one way of treating it.
Q So if his wound was in fact weeping and open on the 21st and Dr. Posch had admitted him and he had debrided the wound and gone to wet and dry dressings, would you consider that some form of malpractice?
A No.
Q So that's something that some physicians would choose to do under those circumstances?
A Treating what you described to me, okay, with that approach, intervention at that point in time I do not object to.
Q If that had been done on that day, would he have developed necrotizing fasciitis over the weekend?
A I have no way of knowing that.
Q Have you ever seen anybody develop necrotizing fasciitis after being admitted to the hospital with a wound as described on the 21st?
A No.
Q Because they'd be watched for signs of

infection in the hospital setting, correct?
MS. KEINKER: Objection.
A No. I'm just saying I haven't seen that. You're asking have I seen a patient with this wound admitted to a hospital develop nec -- no, because, I mean, it's a unique case.
Q Do you have any opinion as to when exactly over the weekend his condition became necrotizing fasciitis?
A I'd say that, you know, sometime, I don't know, over the weekend, Friday night through Monday morning.
Q I presume you have not talked to Dr. Posch about this case?
A Your presumption is correct.
Q Do you have any evidence as to when he received the report of the MRI of the 23rd?
A I reviewed his deposition. It's my impression that when the patient arrived at Dr. Posch's office in preparation for the patient's visit, Dr. Posch had someone from his office obtain a verbal reading of the report.
Q Do you think if Dr. Posch had been informed of the reading of the report on the afternoon of the 23rd, that he should have brought the

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patient in and seen him that day?
A I thmk that -- no, in that it would depend on the patient's symptoms.
Q Well, if his sister is describing his condition as dying and asking for an appointment on Monday for that reason because she says her brother is going to die if he has to wait until the MRI is read and sent over next week, would that be the kind of symptom that would cause you to want to come in on Friday afternoon?
A If a patient -- if someone told me that and I spoke to the patient or the patient's family that their condition was worsening, I would tell the patient to either come see me or be evaluated at -- get to an emergency room if I'm not available.
Q Let's say Jack Rogers had gone to an emergency room on Friday afternoon. Do you think his condition would have been better than it was?
A I have no idea, not knowing what his leg looked like on Friday afternoon.
Q Well, can't you make some presumptions based on the fact he had necrotizing fasciitis on Monday morning?
A Necrotizing fasciitis is something that

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develops pretty rapidly, and Friday afternoon he may have been fine, Friday night he may have had the process kick off, Saturday he may have had a progressive condition.
I mean, it's something that gets turned on and progresses very rapidly, and that's part of the reason why I don't think on the 2 1st he had necrotizing fasciitis.
Q Progressive pain can be a sign of a serious infection in a wound, can't it?
A Yes.
Q And necrotizing fasciitis can develop after a long period of chronic pain and swelling and redness, right? That's too general. Let me ask you a better question.
A Right.
Q Do you think he had any cellulitis before the necrotizing fasciitis?
A He may have.
Q Do you have any opinion as to when he had cellulitis, if at all?
A Sometime between the 2 1st and the 26th.
Q Have you ever heard the phrase transcutaneous gangrene?
A Yes.

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Q Does it ever resemble a thermal burn?
MS. REINKER: Objection.
A Yes -- no -- in that you have dead skin, yes.
Q So their descriptions overlap to some extent?
A Only in that you have -- the appearance of the skin can be similar, but we have a good explanation --
MS. REINKER: There's no -- I'm sorry.
A We have a good explanation for this man's skin injury.
Q Have you ever considered that maybe he did not have a thermal burn at all, that the erythema and the swelling and eventual necrosis was all from infection that developed into necrotizing fasciitis?
A The time frame is not correct.
Q How so?
A He would have had -- he would have been much -- he would have been sicker sooner. It would not have taken from the 15th to the 26th to develop signs of necrotizing fasciitis.
Q Is there, based on your actual experience, what you said about the timing or based on what you've read about it, the time of onset until

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necrotizing fasciitis?
A Both.
Q Have you ever seen necrotizing fasciitis develop all the way from the beginning into necrotizing fasciitis? That's a bad question.
Would you agree that necrotizing fasciitis may also follow a subacute progressive course?
A I'm not familiar with that entity.
Q You've read about his debridement and his subsequent hospital course after his admission?
A Yes.
Q Do you have any opinions, pro or con, about the care he received after he was admitted on the 26th?
A I think he received excellent care.
Q Do you know Dr. Eisengart?
A No, I don't.
Q Do you have any opinion about his current orthopedic condition?
MS. REINKER: Other than what he's read in the depositions you mean?
MR. ROBERTS: I don't see anything in his report about much of anything except the standard of care.

Q Do you have other opinions at trial? I mean, you haven't examined him, right?
A I have not examined the patient.
Q So you don't have any opinion about his current orthopedic condition?
MS. REINKER: Objection. I'm going to ask him -- I may ask him some opinions based on what he's read in depositions and records.
MR. ROBERTS: They're not in his report, so when am I going to hear about it? At trial?
MS. REINKER: Ask him now. Your own expert --
MR. ROBERTS: Do you want to give him a few more answers? You just can't help it, huh?
Q Do you have any opinion about his current orthopedic condition?
A It's my understanding --
Q That he's doing great. I'm kidding.
A My understanding, this patient has a functional leg, he has a knee joint that works, and the patient, I think his major complaint is about some numbness.

Q Would you agree with the statement that if he did not develop necrotizing fasciitis, he would not have been admitted to the hospital, undergone multiple debridement and wouldn't have scars and grafting --
A That's true.
Q -- and all those things?
A Right.
Q That's pretty obvious, right?
A Yes.
Q Do you have any opinion whether he does or does not have diabetic neuropathy now?
A I have no opinion with respect to that.
Q One way or the other?
A One way or the other.
Q Or whether he had diabetic neuropathy back on October 12th '98?
A There's no documentation of diabetic neuropathy back then.
Q There's no testing done.
A I reviewed the medical record. His physicians who have been treating him over the years have done a pretty good job of listing all of his diagnoses, and there's never -- including things such as tic douloureux and things

unrelated to the present problem, and there's never been any indication, or he's never given them any indication that he has a problem with the neuropathy.
Q Would you leave that whole area of expertise to others, like a neurologist, as to whether he did have diabetic neuropathy in October '98?
MS. REINKER: Objection.
A I don't think that anyone can comment about what his neurologic examination was in 1998.
Q Have you read Dr. Conomy's report?
A Yes.
Q Do you disagree with his assessment?
A Yes.
Q In what respect?
A He cannot comment as to the patient's clinical condition in 1998.
Q Some clinical conditions have a very predictable course over the years, don't they?
A Yes.
Q Like osteoarthritis and lots of things?
A Right.
Q Haven't you ever commented on someone's clinical condition years before you examined them, ever given an opinion to that effect?

A I may talk about their pathologic condition, but their clinical condition, no, because I see patients all the time with osteoarthritis of their knees that certainly the arthritis was there years before. They were completely clinically asymptomatic. So what I'm saying is --
Q Would you generally refer neurological pain to someone like Dr. Conomy?
A With respect to making neurologic diagnosis, I guess.
Q You're saying no doctor can tell you what someone's clinical condition was years before without having seen it?
A That's correct.
Q It's not medically possible? It's just not reliable?
A I'd say he has no way of knowing what the patient's sensory examination was in 1998.
Q Wouldn't the fact that he sustained a third-degree burn with a heating pad help him make that conclusion?
A No. I have healthy people, people without diabetic neuropathy, burn themselves with a heating pad.

Q Were they intoxicated?
A No. They're sweet little old ladies.
Q Are they on painkillers?
A No.
Q And you knew they didn't have diabetic neuropathy?
A Yes.
MR. ROBERTS: Okay. I don't have any more questions.
MS. REINKER: Okay. You're going to have this written, right, I presume?
MR. ROBERTS: Yes.
MS. REINKER: At some point he will have this transcribed, and you will have the right to review the transcript to make any corrections in it that you think are necessary. And I suggest that you do that in any kind of a case like this. So he will not waive signature.
THE WITNESS: Okay. I will not waive signature.
(Deposition concluded at 7:50 p.m.)
(Signature not waived)

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Louis Keppler, M.D.

State of Ohio,
SS: CERTIFICATE
County of Cuyahoga

I, Phyllis L. Englehart, RMR and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, Louis Keppler, M.D., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to computerized stenotypy in the presence of said witness, afterward transcribed, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and completed without adjournment.

I do further certify that I am not a relative, counsel, or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 24th day of April, 2001.

Phyllis L. Englehart, RMR and Notary Public
in and for the State of Ohio.
My commission expires June 23, 2001

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