Henry M. Lerner, M.D.
196 Windsor Road
Newton, MA 02468
(617) 332-9392
Email: hrnlerner@aol.com

June 9,2002

Julie A. Callsen
Bonezzi, Switzer, et. al.
Leader Building, Suite 1400
526 Superior Avenue
Cleveland, Ohio 44114-1491

Re: Angela Mattio v Dina DiCenzo, D.O.

Dear Ms. Callsen:

At your request I have reviewed the records of Angela Mattio fiom the following sources:

Southwest General Hospital
Parma Community Hospital
The offices of doctors:
Dina Dicenzo, D.O.
Timothy Klatt, M.D.
Cynthia Austin, M.D.
The transcript of Dr. DiCenzo's deposition

Below is a brief review of the facts of this case:

Dr. Dicenzo first saw Ms. Mattio on 9/15/99. Ms. Mattio had been referred by her PCP, Dr. Dravid, because of right pelvic pain and a 4.4 **x 3.1** cm ovarian cyst seen on ultrasound 7/13/99. Ms. Mattio also complained of irregular menses over the preceding **2** years.

Ms. Mattio's medical history was significant for pelvic inflammatory disease in 1990, a right tubal pregnancy in 1991 resulting in loss of part of her right fallopian tube, and four subsequent miscarriages. She also suffered fiom significant for peptic ulcer disease, depression, and anxiety. Ms. Mattio was 5 ft tall and weighed 212 pounds.

At the time of Dr. DiCenzo's 9/15/99 examination of Ms. Mattio, Dr. Dicenzo noted right adnexal fullness and tenderness. She prescribed the birth control **pill** for Ms. Mattio in an effort both to shrink down the cyst and to regular Ms. Mattio's periods. She also asked Ms. Mattio to return for an ultrasound exam in 2 weeks.

At the time of that ultrasound examination on 9/30/99, performed by Dr. DiCenzo herself, the cyst was still seen to still be present and to have approximable the same dimensions. Dr. DiCenzo also noticed a septum in the cyst. Because the cyst had persisted over a ten week period and because of the patient's persistent pelvic pain, Dr. DiCenzo decided to evaluate the cyst laparoscopically with an eye towards removing it.

On October 25, Ms. Mattio underwent an operative laparoscopy. At the time of surgery Dr. DiCenzo saw the cyst to be the size seen on ultrasound. She also described it as tense and as appearing to have solid components. For that reason Dr. DiCenzo wished to remove the cyst intact and not drain it.

Dr. DiCenzo laparoscopically excised the cyst from the right ovary and attempted to remove it with an Endo bag. During the first attempt to get the bag out through laparoscopic incision the bag broke. A second attempt was made, this time after attempting to decompress the cyst. Again the Endo bag ruptured. Initial attempts to locate the cyst following this second rupture were unsuccessful. In order to locate the cyst Dr. DiCenzo proceeded to laparotomy. Despite opening the abdomen she was still unable to find the cyst. After looking for some time, she closed the fascia and, using the laparoscope once more, sought the cyst. She found it and reopened the fascia widely enough to remove the cyst.

Post operatively Ms Mattio experienced considerable incisional pain but otherwise recovered uneventfully. She was discharged to home 3 days after surgery. She was readmitted to the hospital November 1, 1999 following an office visit at which time she complained of severe burning in the left edge of her incision. She also reported having a fever of 102 accompanied by nausea and vomiting. She was already on Cipro to treat a suspected urinary tract infection.

An attempt was made during the hospitalization to drain the incision but no pus was uncovered. The patient was treated with additional antibiotics and rapidly became afebrile. She was discharged to home on zithromax and Cipro.

On February 15,2000 Ms. Mattio saw Dr. Klatt for gyn care and to discuss getting pregnant. Dr. Klatt's note says that Ms. Mattio had had a wound infection for 2 months but that the incision was now well healed. After extensive evaluation he diagnosed Ms. Mattio as having polycystic ovarian syndrome. A hystosalpingogram performed 5/23/00 showed that the right ovarian tube was short but that the left ovarian tube was of normal length and spilled dye freely. Ms. Mattio was also noted to have a persistently elevated sedimentation rate, a measure of systemic infection, inflammation, or immune disease.

On September 15,2000 Ms. Mattio saw a Dr. Cynthia Austen who says that the infection from the 1999 surgery did not appear to have involved the endometrium in any way.

From the information provided in the medical records I conclude the following:

1. I see no deviation in the standard of care by Dr. DiCenzo in her pre-operative, surgical, and

post-operative care of Ms. Mattio.

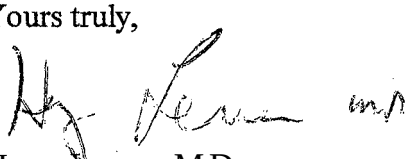
In the first place, the surgery Dr. DiCenzo performed on Ms. Mattio was entirely appropriate. **Ms.** Mattio had a months' long history of pelvic pain and had an ovarian cyst that had been present for at least 10 weeks. Laparoscopy was appropriate to rule out endometriosis, endometrioma, or other ovarian neoplasm.

Secondly, the surgery was performed in routine, standard fashion. It was absolutely necessary to try to prevent cyst fluid—which might have been malignant—from spilling into Ms. Mattio's abdominal cavity. For that reason the decision to attempt to remove the cyst with the Endo bag without first draining it was correct. The fact that it proved difficult to get a tense 4 cm cyst out of a laparoscopy incision is not surprising. This situation happens frequently to all gynecologists. That Dr. DiCenzo had to perform additional surgery to remove the cyst was unfortunate but was entirely appropriate. It is the sort of complication that anyone who performs laparoscopic surgery can expect from time to time.

Finally, there appears to be no significant damages caused by Ms. Mattio's October 25, 1999 surgical procedure. Ms. Mattio experienced a longer hospital stay than she otherwise would have had if a laparotomy had not been performed and she underwent some degree of pain post-operatively. She also had a post-operative infection--although the CT scan report did not show any definite abscess or wound serorna. But Ms. Mattio had already had tubal damage and pelvic scarring, likely from her pelvic inflammatory disease in 1990. The fact that she had a tubal pregnancy in 1991 shows that her tubes were already damaged then. Thus any claim that Dr. DiCenzo's procedure made Ms. Mattio infertile is untenable. In addition, a further major infertility factor was diagnosed by Dr. Klatt: Polycystic ovarian syndrome. This condition has nothing to do with Dr. DiCenzo's surgery.

Please let me know if you have any questions for me.

Yours truly,



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