

#634

1 THE STATE of OHIO, :  
2 COUNTY of CUYAHOGA. : SS:

3 -----

4 IN THE COURT OF COMMON PLEAS

5 -----

6 ARAZINE SMITH, executrix of the :  
7 ESTATE of CAROLYN YARBOROUGH, :  
8 plaintiff, :

9 vs. : Case No. 326850

10 SAINT LUKE'S HOSPITAL, :  
11 defendant. :

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13 Deposition of PHILLIP LERNER, M.D.,  
14 a witness herein, called by the plaintiff for the  
15 purpose of cross-examination pursuant to the Ohio  
16 Rules of Civil Procedure, taken before Constance  
17 Campbell, a Notary Public within and for the State  
18 of Ohio, at Mount Sinai Hospital, One Mount Sinai  
19 Drive, Cleveland, Ohio, on TUESDAY, JUNE 30TH,  
20 1998, commencing at 1:40 p.m. pursuant to agreement  
21 of counsel.

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23

24

25

APPEARANCES:

ON BEHALF OF THE PLAINTIFF:

Donna Taylor-Kolis, Esq.  
Donna Taylor-Kolis Co., LPA  
330 Standard Building  
Cleveland, Ohio 44113  
(216) 861-4300.

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ON BEHALF OF THE DEFENDANT I.M. SONPAL, M.D.:

Gary H. Goldwasser, Esq.  
Reminger & Reminger  
The 113 Saint Clair Building  
Cleveland, Ohio 44114  
(216) 687-1311.

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ON BEHALF OF THE DEFENDANT STEVEN BASS, M.D.:

Marilena DiSilvio, Esq.  
Reminger & Reminger  
The 113 Saint Clair Building  
Cleveland, Ohio 44114  
(216) 687-1311.

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I N D E XWITNESS:PHILLIP LERNER, M.D.PAGE

Cross-examination by Miss Kolis

4

(NO EXHIBITS MARKED)

(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

1                   PHILLIP LERNER, M.D.

2       of lawful age, a witness herein, called by the  
3       plaintiff for the purpose of cross-examination  
4       pursuant to the Ohio Rules of Civil Procedure,  
5       being first duly sworn, as hereinafter certified,  
6       was examined and testified as follows:

7                   -----

8                   MISS KOLIS:               Dr. Lerner, as  
9       you know my name is Donna Kolis, we've just been  
10      introduced. I have been retained to represent the  
11      Estate of Carolyn Yarborough. My purpose today is  
12      to ask you hopefully fair and concise questions to  
13      clarify the material in the expert report you  
14      prepared. Do you have a copy of your expert report  
15      available?

16                   MR. GOLDWASSER:       Now he does.

17                   MISS KOLIS:           The answer is  
18      yes. Absolutely.

19                   -----

20                   CROSS-EXAMINATION

21      BY MISS KOLIS:

22      Q.       Before we go on with that, for the record,  
23      would you state your name and your professional  
24      address.

25      A.       Phillip I. Learner. My professional address

1 for the rest of today is the Mount Sinai Medical  
2 Center.

3 Q. I appreciate that.

4 Prior to today's deposition Mr.  
5 Goldwasser did favor me with a copy of your  
6 curriculum vitae. If you would quickly look at it  
7 to make sure this is your current and complete CV,  
8 it's the same one Gary handed you I'm sure.

9 A. Yes, this is it.

10 Q. Thank you, Doctor. I'm not going to go  
11 through your medical background. I think it's  
12 self-explanatory. I had a couple questions however  
13 to discuss. It could be the fault of the reader of  
14 the CV, not the preparer.

15 Are you Boarded?

16 A. No.

17 Q. I didn't notice so, I wasn't certain. You  
18 have never obtained a Board in internal medicine or  
19 infectious disease?

20 A. Correct.

21 Q. Fair enough, thank you very much.

22 Additionally, Doctor, have you done  
23 any research or writing specifically focused on the  
24 two organisms I'm going to want to talk about,  
25 Enterococcus or Candida?

1 A. Yes and no.

2 Q. Can you explain your answer for me?

3 A. Some of the papers, review papers on the  
4 various Streptococcal infections that our group in  
5 Cleveland reported probably included cases wherein  
6 Enterococcus and yeast were involved, they weren't  
7 a major part of the paper.

8 Q. I guess I would be fairly certain if I went  
9 to the library, if I had the time, and pulled every  
10 article, I'm not going to find you have written  
11 anything specifically directing itself to the issue  
12 of when you do or don't cover for those organisms;  
13 that's a fair statement?

14 A. Okay.

15 Q. I don't want to put words in your mouth, I'm  
16 checking to see if you feel anything contained in  
17 your CV is fact specific to this case?

18 A. I would say no.

19 Q. I gather, based upon my own investigation,  
20 this is not the first time you've appeared as an  
21 expert witness?

22 A. Correct.

23 Q. Doctor, have you testified on behalf of a  
24 patient in the past?

25 A. Yes.

1 Q. About how many times?

2 A. It's 60/40.

3 Q. Fair enough. I didn't know, I don't have all  
4 that data available.

5 MR. GOLDWASSER: 60/40 for  
6 plaintiffs?

7 THE WITNESS: No, 60/40 for  
8 defense.

9 Q. The cases that you've been asked to testify  
10 for on behalf of the patient, were those cases  
11 where you were involved as a subsequent treating  
12 physician, or just simply cases that you were  
13 contacted by plaintiffs' attorneys?

14 A. To the best of my recollection I have had  
15 only one case in which I was personally involved as  
16 a treating physician.

17 Q. When was the last time you testified in court  
18 on behalf of a plaintiff?

19 A. It's hard to say. I really don't keep track  
20 of that. I would say probably about two years ago.

21 Q. Can you tell me what attorney that was you  
22 testified for?

23 A. I would have to look it up.

24 Q. Without belaboring things I have to cover  
25 these issues, I did a docket search in Cuyahoga

1 County, noted you've been sued a couple times, we  
2 will say a couple, the docket is not clear. Does  
3 that comport with your memory, you have been sued a  
4 couple times?

5 A. No, only one lawsuit went through.

6 Q. Let me ask my question better.

7 It appeared you've been sued four  
8 to five times, only one of the cases resulted in a  
9 settlement against you, that's the better  
10 statement.

11 A. No, I don't believe that is an accurate  
12 statement.

13 Q. Okay, maybe I don't know how to research the  
14 docket. I didn't bring them with me.

15 A. Only one case as far as I can recall was ever  
16 pursued. I've been named in a number of  
17 preliminary investigations. I was one of 14  
18 doctors named in an outpatient continuum that every  
19 doctor who had ever seen the patient was named.

20 Q. Your recollection is you paid no medical  
21 negligence claims?

22 A. Zero.

23 Q. You currently have a lawsuit pending against  
24 you, unless this information has changed in the  
25 last two weeks, filed by a Dr. Catherine Crouse?



1 MR. GOLDWASSER: She is the  
2 plaintiff?

3 MISS KOLIS: Yes.

4 MR. GOLDWASSER: Catherine  
5 Crouse?

6 A. There was a house officer who sued.

7 Q. Yourself and the hospital?

8 A. That was dismissed years ago.

9 Q. This one looked like it's pending. These  
10 dockets are only as good --

11 A. If this is the one you are referring to, a  
12 house officer felt we hadn't evaluated her fairly,  
13 that case was dismissed a number of years ago.

14 Q. The Common Pleas docket doesn't reflect that,  
15 that is why I asked the question. They are only as  
16 good as the bureaucrats that input the  
17 information. That suit is not pending, correct?

18 A. It was thrown out.

19 Q. Doctor, in your career here at Mount Sinai I  
20 assume -- I'm calling it your career at Mount Sinai  
21 because that's primarily where you practiced in the  
22 25 years?

23 A. 25 years.

24 Q. Have you sat on a peer review committee for  
25 the hospital?

1 A. I'm not sure the hospital has a specific peer  
2 review committee.

3 MR. GOLDWASSER: Talking about  
4 quality assurance committee?

5 Q. I call it peer review. I'm asking if as part  
6 of your responsibility at the hospital you've been  
7 asked to sit and evaluate patient care?

8 A. There are a number of activities that relate  
9 to evaluating physician performance and patient  
10 care. Some of them are official, some of them are  
11 unofficial.

12 Q. Have you participated in any official  
13 capacity in evaluating the performance of your  
14 peers?

15 A. As the chairman of the infectious control  
16 committee items have come to the attention of the  
17 committee through my nurse or other surveillance  
18 situations that have required me to make a judgment  
19 and/or intervene in circumstances that I felt were  
20 inappropriate for infection control. This has to  
21 do with personal health service as well as  
22 practitioners in various specialties or portions of  
23 the hospital.

24 Q. So is the answer you don't sit officially on  
25 a board that does quality assurance reviews of

1 particular cases in the hospital?

2 A. Well, again, there is no -- there is a -- for  
3 years I was on the surgical evaluation committee.  
4 This was the -- what was it called. I can't  
5 remember the name of the committee. I was a member  
6 of the committee that reviewed surgical  
7 performance, not just from infection control, a  
8 variety of situations.

9 There was at one point the tissue  
10 committee. That's what it was called, the tissue  
11 committee. It's changed in recent years. At one  
12 point in time the tissue committee was a group of  
13 physicians who got together and reviewed the  
14 pathologic material that passed through the  
15 pathology department over a period of time. If  
16 there was any deviations from accepted standards  
17 the committee would investigate and pass judgment  
18 and notify the physicians if something was felt to  
19 be inappropriate.

20 Q. Fair enough answer.

21 I assume that you are going to  
22 charge me for the time we spend together today?

23 A. It's delightful to be with you, but it's  
24 going to cost you.

25 Q. Can you tell me what you will be charging me

1 an hour for testimony today?

2 A. \$300.

3 Q. As it regards this case, specifically the  
4 care and treatment of organisms that were found in  
5 this patient, is there any literature that you feel  
6 supports the position that you've taken in your  
7 report?

8 A. First of all what we're talking about is not  
9 the care and treatment of the organisms, we're  
10 talking about the care and treatment of the  
11 patient.

12 Q. Of course.

13 A. It's an important point to make because what  
14 we do is take care of patients and treat patients  
15 based on the data accumulated in a given point in  
16 time, which includes laboratory results as well as  
17 a physical examination, general overall  
18 evaluation.

19 The two organisms in question here  
20 are ubiquitous organisms, everybody has them in  
21 small numbers. They happen to be very commonly  
22 recovered because they are resistant to the usual  
23 antibiotics that are administered in a situation  
24 similar to what transpired here.

25 Candida is an organism that is

1 present in very small numbers in everybody, in the  
2 intestinal tract of every person, and so that  
3 finding them in a polymicrobial infection is not  
4 entirely surprising, not entirely rare.

5 The Surgical Infectious Disease  
6 Society has issued a number of papers over the  
7 years describing their indication for use of  
8 antibiotic therapy. I've been trying to find a  
9 reference for this, I've been unsuccessful because  
10 I'm so busy doing other things. So Jeff Solomkin,  
11 S-o-l-o-m-k-i-n, from Cincinnati, who is a very  
12 well known surgeon, active in the Surgical  
13 Infectious Disease Society, has written himself or  
14 as part of a surgical society issue, has raised  
15 this point about Candida as part of a polymicrobial  
16 infection, whether or not it requires specifically  
17 treatment when it's part and parcel of a mixed  
18 infection in this setting.

19 Q. Let me ask you a question, Dr. Lerner, since  
20 you brought up Dr. Solomkin's name.

21 Have you been able to read his  
22 publication on Candida?

23 A. As I've said, I've not been able to go to the  
24 literature, I've been tied up with other things. I  
25 wrote him a letter asking him to give me a

1 reference to that phenomenon. I've not received a  
2 response.

3 Q. Would you have written to him because he is  
4 someone that you recognize as authoritative on the  
5 issue of Candida?

6 A. I wrote to him because that is where I first  
7 heard the concept of not treating Candida, not  
8 necessarily treating Candida when it is part of a  
9 polymicrobial infection.

10 Q. We will ask you some medical questions  
11 later.

12 To answer the question that I asked  
13 you: I gather that you could have selected one of  
14 I don't want to say thousands of people, but one of  
15 a fair number of physicians to write to for a  
16 reference, he is the doctor that you selected?

17 A. He's the one that first brought this concept  
18 to my attention.

19 Q. Fair enough.

20 Back to the question, I think you  
21 partially answered it, I want to be certain so I'm  
22 not kicking myself at trial in a couple weeks.

23 Other than the effort that you've  
24 made to contact Dr. Solomkin on the issue of  
25 Candida, any other written material that you feel

1 establishes the standards of care as to when or  
2 when you would not cover for Candida specifically?

3 A. I'm not sure. There may be some guidelines  
4 somewhere, I haven't had the opportunity to review  
5 the literature in any detail.

6 Q. Is it your intention to research the  
7 literature in an effort to find written guidelines  
8 prior to the time you testify at trial?

9 A. I might if it's necessary.

10 Q. I will ask you directly that if you do  
11 research this, you discover some guidelines you are  
12 going to want to discuss in court, you immediately  
13 make that available to Mr. Goldwasser so he can  
14 give it to me, so I question you about it at  
15 trial.

16 A. I'd be happy to do that.

17 Q. I see that you came without a file today; is  
18 that a fair statement?

19 A. I always come without a file.

20 Q. Good enough. Makes it easier I suppose.

21 Referring you to your expert  
22 report, it indicates that you were contacted on  
23 December 3, 1997, right?

24 A. Yes.

25 Q. First line says that?

1 A. Yes.

2 Q. Your report is dated May 29th. I want to  
3 cover some of the basics.

4 It says that you have reviewed the  
5 materials forwarded, listed as six items. Can you  
6 tell me, Doctor, from your memory or with coaching  
7 from Mr. Goldwasser, what six items you reviewed in  
8 reaching your opinions in this matter?

9 A. Without having his cover letter I would --

10 MR. GOLDWASSER: I don't have my  
11 file with me. I know I sent you the deposition of  
12 Dr. Bass.

13 A. Dr. Bass' deposition, the two confinements.

14 Q. At Saint Luke's?

15 MR. GOLDWASSER: Sent you the  
16 expert reports, I believe.

17 A. The two expert reports subsequently were sent  
18 to me separately.

19 MR. GOLDWASSER: Right. Meridia  
20 Huron Road record.

21 A. Meridia Huron Road record and the nursing  
22 home records.

23 Q. Since that time obviously your report also  
24 reflected did you receive the reports of my  
25 experts, Dr. Holzman and Dr. Chung?



1 A. Yes.

2 Q. Have you also received a rather large  
3 quantity of additional medical records that  
4 predated this particular confinement, the Saint  
5 Luke's confinement? Mr. Goldwasser was shaking his  
6 head.

7 MR. GOLDWASSER: We didn't send  
8 them to him. The only thing I sent him recently  
9 was the Candlewood Nursing Home records during that  
10 four, five days before she crashed.

11 Q. Would you have had the Candlewood Nursing  
12 Home record before you prepared this report; am I  
13 stating that accurately?

14 A. No, I got those records after the report.

15 MR. GOLDWASSER: I just sent it  
16 to him recently.

17 Q. Have you had an opportunity to review those  
18 records?

19 A. Yes, I did.

20 Q. Anything contained in those records affect  
21 opinions that you've set forth in your report?

22 A. Only that my opinion or what I could glean  
23 from the record suggested that something  
24 catastrophic happened just before she was  
25 transferred back into the hospital. She seemed to

1 be doing reasonably well on the first four days  
2 back at the nursing home.

3 Q. We will probably go over that.

4 So you are telling me what you  
5 wrote in this report was written without the  
6 benefit of having the nursing home records?

7 A. That's correct.

8 Q. We'll get to that in its logical order then.

9 Are you acquainted with either  
10 Dr. Chung or Dr. Holzman in any way?

11 A. No.

12 Q. Since the time you authored this report, up  
13 through and including today, have you seen the  
14 expert report of Dr. Donald Frey?

15 A. No.

16 Q. Are you aware Dr. Frey had been retained to  
17 testify on behalf of the physicians?

18 A. I've heard that.

19 Q. Do you know Dr. Frey?

20 A. Yes.

21 Q. Did you know Don when he was here in town?

22 A. Yes.

23 Q. How would you describe the relationship  
24 between the two of you, friends or colleagues or  
25 both?

1 A. Just acquaintances.

2 Q. Fair enough.

3 A. I testified at his VA inquisition.

4 Q. At Ohio State?

5 A. No, here, VA.

6 Q. I thought you said BA. I'm trying to think  
7 an inquisition for a BA.

8 A. No, VA here went after him for some petty  
9 reason. I had previously dealt with them on a  
10 similar issue so I offered my moral support.

11 Q. And your testimony I gather?

12 A. Yes.

13 Q. Good enough.

14 Without belaboring it because this  
15 isn't the primary issue in this case, I'm curious  
16 as to whether or not you sufficiently reviewed  
17 the records to have determined on your own  
18 independently the cause of Mrs. Yarborough's  
19 underlying muscle weakness in her extremities?

20 A. I did not pay attention to that.

21 Q. Did what the cause of her muscle weakness was  
22 have anything to do one way or the other with the  
23 issues we're going to talk about? That was a  
24 poorly asked question.

25 A. No, only insofar as it required the use of

1 very large doses of corticosteroids.

2 Q. You obviously understood my question, I  
3 didn't need to withdraw it.

4 You don't have an opinion she  
5 wasn't required to be on corticosteroid therapy, do  
6 you?

7 A. No.

8 Q. Is it your intention at the trial which is  
9 coming up I think two weeks from today of offering  
10 opinions that are supportive of Dr. Sonpal and  
11 Dr. Bass?

12 MR. GOLDWASSER: He hasn't been  
13 asked. He knows about Dr. Bass, I don't know about  
14 Sonpal.

15 A. I don't know.

16 Q. The reason I'm asking, it's not that  
17 important, I do like to know ahead of time so we  
18 can cover the issues. You said I offer the  
19 following comments related to Dr. Steven Bass'  
20 involvement, I guess at this point you perceived  
21 your role as testifying on behalf of Dr. Steven  
22 Bass?

23 A. That is --

24 MR. GOLDWASSER: In fairness,  
25 he's obviously an ID expert, as relates to that,

1 Dr. Sonpal as relates to ID, he may be asked to  
2 comment upon. As a surgeon per se, he will not.

3 Q. Do you perceive an issue as to surgical  
4 technique in this case?

5 A. No.

6 Q. You may be offering an opinion to reasonable  
7 degree of medical probability on behalf of both of  
8 these physicians; is that an accurate statement?

9 A. If there is ID questions about the surgery.

10 Q. Not a problem.

11 Are you suggesting by the report  
12 that you have written that Mrs. Yarborough was not  
13 an immunocompromised patient as of the date of her  
14 admission 1-10-96 at Saint Luke's?

15 A. In the context of anyone receiving these  
16 corticosteroid medications in the doses she was  
17 receiving, she automatically has to be considered  
18 immunocompromised.

19 Q. I would like to clarify that so we have a  
20 place to speak from because when I read your report  
21 I was surprised, that's because I'm not a doctor I  
22 suppose, your last sentence, "Whether or not this  
23 woman's steroid requirement automatically  
24 arbitrarily placed her in a different category of  
25 susceptibility is also open to discussion;" do you

1 recall writing that?

2 A. Yes, that is in relation to a statement that  
3 preceded that. Specifically in relationship to  
4 events at the time the antibiotics were  
5 discontinued and then Dr. Bass saw her and the time  
6 she was discharged.

7 The purpose of that statement was  
8 merely to state that the fact she was receiving  
9 large but decreasing doses of steroids did not  
10 impact the things that were or were not done in  
11 those final five days in the hospital.

12 Q. Let's see if we can reach some point of  
13 agreement so I hopefully will have an intelligent  
14 conversation with you today.

15 You agree with me because of the  
16 dosage and duration of the steroids which she  
17 received that she was an immunocompromised patient?

18 A. She was compromised from the point of view of  
19 corticosteroid administration in these doses.

20 Q. Because the corticosteroids do what to T cell  
21 function?

22 A. They are a lympholytic, they destroy  
23 lymphocytes that impact the cell mediated immune  
24 system. Response to infection on the part of the  
25 host is also antibody mediated, hemoimmunity. Most

1     importantly of all it relates to the recruitment of  
2     white blood cells, the polymorphonucleated  
3     leukocytes from the area in the blood where they  
4     are margined and stored, in turn directed toward  
5     the area of need where the inflammation is going  
6     on.

7                     That is probably the single most  
8     potent result of the steroid dose she was getting,  
9     its impact on the white blood cell release from the  
10    marrow and recruitment to the site of infection or  
11    injury.

12    Q.     In layman's terms, if we can do it that way,  
13    what you are saying is probably the same thing I'm  
14    saying, the administration of corticosteroids,  
15    Prednisone in this case, suppresses the body's  
16    ability for the white cells to work as they are  
17    supposed to; that's a fair way to state it?

18    A.     It alters the production, release and  
19    transport of white cells. Those are the three  
20    areas that the host defense exhibited by the white  
21    cells impacts on our response to infection; the  
22    production in the bone marrow, the transport  
23    through the blood stream and the arrival at the  
24    site of inflammation or injury where the white  
25    cells are needed to attack the bacteria that are

1 multiplying.

2 Q. I think we're saying the same thing, you just  
3 give a much better definition because that is what  
4 you do, right?

5 A. Correct.

6 Q. In terms of an assertion, if made by anyone  
7 in this case, that the use of corticosteroids  
8 increases the white blood count without being  
9 indicative of infection, explain in layman's terms  
10 how that works.

11 A. The usual situation where an infectious  
12 disease person gets called into a case such as this  
13 where the white count remains elevated or  
14 persistently climbing, in a patient who looks as  
15 though he or she is doing well otherwise.

16 That is one of the single most  
17 important parts of this case, which is that several  
18 days after all antibiotics were discontinued, at a  
19 time when Dr. Bass was asked to evaluate her wound  
20 infection, this lady's white blood cell count was  
21 coming down. Over the course of the next several  
22 days it fell still further or remained about the  
23 same.

24 This is exactly the opposite of the  
25 problem that the ID person usually confronts in



1     this setting with persistently elevated white count  
2     or a gradually increasing one, where the  
3     significance of that is unknown because it could be  
4     white cell mobilization from the marrow influenced  
5     by steroids, it could be a signal from the site of  
6     inflammation to send more white cells, we're in  
7     trouble down here.

8                     There is no test that we have  
9     available at this point in time that helps us  
10    distinguish between those two events.

11                    The salient feature of this case is  
12    the fact the white count was returning toward  
13    normal while the patient was off of antibiotics and  
14    still receiving large doses of steroids.

15    Q.     We're going to probably have to get into  
16    specifics on that. I heard what you said.

17                    Let me ask this: In doing a white  
18    blood count and looking at differentials and segs  
19    and bands, what does the increase in bands mean to  
20    you?

21    A.     Increase in that is an easy question because  
22    the increase in bands means younger forms are being  
23    released early from the bone marrow, before they  
24    had a chance to mature. This is a general  
25    phenomenon when the marrow is distressed or when

1     there is an urgent signal from the site of injury  
2     or infection, send more white cells, we will worry  
3     about them growing up once we get them.

4     Q.     You agree an increase in bands can be a  
5     signal of lurking infection?

6     A.     Increase in bands is a sign the marrow is  
7     under stress and responding to it. The sources of  
8     stress to the marrow are many.

9     Q.     What are the sources of stress to the marrow  
10    when one usually sees the increase in bands?

11    A.     That is a signal from the area of injury or  
12    inflammation that is stronger and persistent.

13    Q.     In terms of reference ranges for bands, you  
14    use references ranges at this hospital?

15    A.     I'm sure we do. I have no idea what they  
16    are.

17    Q.     Without looking at the chart, do you know  
18    what the reference range is for bands in terms of  
19    what would be considered normal?

20    A.     In the upper limits of normal is five.

21    Q.     So bands of 10 would not necessarily be real  
22    good -- let me rephrase the question, that was like  
23    we were talking at a coffee table.

24                 A bands of 10 portends -- we don't  
25    know the absolute white count number, a bands of 10

1 would suggest a response from the bone marrow to  
2 either injury or infection; would you agree with  
3 that statement?

4 A. It reflects the fact younger cells are being  
5 released. That is all it signifies.

6 Q. In terms of --

7 A. Let's get something straight up front, this  
8 will save us a lot of difficulty in circling the  
9 situation without being precise.

10 When you do a white blood cell  
11 count, you are taking a snapshot of a dynamic  
12 process. The dynamic process is production,  
13 transportation and target of white cells.

14 Depending on when you take that  
15 snapshot you can get a widely varying picture. You  
16 take the beginning of that process, you may have  
17 fewer bands than you would find three or four hours  
18 later when the process is revved up, you take an  
19 entire snapshot. That's all the white cell count  
20 and differential is, a snapshot of a dynamic  
21 process.

22 Q. Should you not rely on it to help you make a  
23 diagnosis of ongoing infection?

24 A. It's the only tool we have, limited though it  
25 is. You must understand it's a lab test that is

1       influenced by the circumstances under which it is  
2       obtained. To say something is bad or good is very  
3       difficult in that setting.

4       Q.       Is that equally true in the setting where you  
5       have the person who is on steroids, you can't  
6       always rely on the white blood count, the raw  
7       numbers, forget the segs or bands, going up or down  
8       to be indicative of no infection?

9       A.       Absolutely. The steroids can influence which  
10      way they are heading, it is going to interfere with  
11      your interpretation.

12     Q.       Let's move on to a different question.

13                     Doctor, have you studied these  
14      records sufficiently enough to render an opinion in  
15      this case as to why Mrs. Yarborough's colon  
16      perforated to begin with on or about 1-9-96?

17     A.       No.

18     Q.       You have no opinion on that issue?

19     A.       There are lots of reasons why there are  
20      perforations and fecal soilage of the peritoneal  
21      cavity.

22     Q.       You have not studied the record sufficiently  
23      as of today to render an opinion as to the cause of  
24      the perforation itself?

25     A.       Correct.

1 Q. Did you in preparation of this report review  
2 the hospitalization of 12-23 to 1-5, the one that  
3 precedes the perforation?

4 A. I may have looked superficially, I didn't  
5 study it.

6 Q. You didn't look at it to render your opinion  
7 regarding the final hospitalization at  
8 Saint Luke's?

9 A. No.

10 Q. If you didn't go through it real  
11 specifically -- I didn't mean to imply you didn't  
12 look at those, I assume you looked at the records?

13 A. I looked at them with the idea of trying to  
14 find out when she was placed on steroid  
15 medication. When I looked it was precisely for  
16 that particular point only.

17 Q. Did you happen to know what her baseline  
18 white blood count was when it was first taken at  
19 Saint Luke's in the confinement of December 23rd  
20 through 1-5?

21 A. I don't recall.

22 Q. Would you in treating this patient find that  
23 information helpful to indicate to you at any given  
24 time what a white blood count might mean?

25 A. No, because you had a different set of

1 stimuli and circumstances on the subsequent  
2 admissions.

3 Q. Fair enough.

4 I take it she wasn't septic in the  
5 December, 1995 admission?

6 A. There was no evidence for it at that time.

7 Q. I think we've covered this a little bit, I  
8 want to ask you a couple of additional questions  
9 about the affects of steroids on the body itself.

10 How can the administration of  
11 steroids in the doses which Carolyn Yarborough was  
12 receiving them affect fevers?

13 A. Steroids are very potent antipyretics,  
14 antipyretics being medication that reduces fever.  
15 Among the most potent that we have.

16 Q. Let's see if you agree, this is a very  
17 general statement, it's believe me not out of a  
18 textbook.

19 If I'm a doctor, God forbid, if I  
20 was the doctor, my patient was on steroids, I'm  
21 looking at a temperature chart, I know she is  
22 consistently on them, can I presume that if she is  
23 off steroids the fever might actually be higher?

24 A. What kind of temperatures are being recorded  
25 on the steroids, normal temperature?

1 Q. Let's see. They are always a little above  
2 normal, sometimes as high as 103.

3 A. On steroids?

4 Q. On steroids.

5 A. Not 100.3, 103?

6 Q. 103.

7 A. Then definitely.

8 Q. Definitely what?

9 A. You can have more fever off of steroids than  
10 you would have on.

11 Q. Have you charted the fevers in this patient  
12 for the hospitalization at Saint Luke's from 1-9-96  
13 through --

14 A. I may have looked at the peak temperature, I  
15 don't recall charting them.

16 Q. Do you have an opinion based on an analysis  
17 of the record if at any time Mrs. Yarborough was  
18 experiencing a fever from antibiotic  
19 administration?

20 A. That's a very difficult diagnosis to make.  
21 It's a common event. We have no test for it. As a  
22 matter of fact, steroids would interfere with the  
23 one test that we do have, which is the appearance  
24 of eosinophils in the serum blood because steroids  
25 suppress eosinophils.

1 Q. That is a random issue that comes up as an  
2 addition. I was asking if you have an opinion she  
3 was experiencing a fever from antibiotic therapy at  
4 any time?

5 A. It's a very difficult diagnosis to make  
6 because the eosinophils are what is altered in the  
7 steroid administration.

8 Q. You agree that steroids will affect first of  
9 all a patient's response to pain? If you don't  
10 understand what I mean, I'll be more definite.

11 A. Being that the steroids are an  
12 anti-inflammatory they reduce pain, they reduce the  
13 inflammation and swelling associated with injury or  
14 inflammation.

15 Q. Would you agree a patient could potentially  
16 have an infective process occurring in the abdomen,  
17 not have classic signs based on the rigidity or  
18 other symptoms because they are on steroids?

19 A. That is an absolutely correct statement.

20 Q. If it inhibits the body's ability to mount  
21 that kind of a classic response, would it interfere  
22 with the patient's perception of pain coincident  
23 with an intra-abdominal infection?

24 A. Yes.

25 Q. Taking a sentence out of your report, I'm



1 going to read it to you, you can locate it, I don't  
2 think I would misquote you, but you stated "Whether  
3 or not a specific antibiotic treatment directed at  
4 the same two organisms recovered at the time of  
5 death, Enterococcus and Candida, would have  
6 prevented the event that took place is problematic  
7 and conjectural;" do you remember writing that  
8 sentence?

9 A. Yes.

10 Q. Can you explain that to me with as much  
11 specificity as possible?

12 A. The charge in this case is the fact the  
13 doctors didn't address the specific organism  
14 originally cultured from the stool that had soiled  
15 the peritoneal cavity, subsequently found in the  
16 wound, was cultured postoperatively. The charge  
17 seems to be the doctors were negligent and  
18 irresponsible for not giving specific antibiotics  
19 directed at those two organisms.

20 Q. And?

21 A. And merely stated that it's arguable from a  
22 number of points of view as to whether or not  
23 treating organisms as the laboratory reports them  
24 out is the way you use antibiotics, or whether we  
25 treat patients as opposed to treating cultures.

1                   At any given point in time when you  
2                   are evaluating a sick patient you use the database  
3                   available to you at that time. Things change,  
4                   alter on an hourly or day-to-day basis.

5                   The salient feature of this woman's  
6                   postoperative course at the time she came into the  
7                   hospital with the perforated colon and fecal  
8                   soilage was persistent continued improvement and  
9                   recovery by almost every measure one can obtain.

10                  The fact that steroids may mask  
11                  fever, may mask inflammation, may mask some of the  
12                  physical findings is absolutely true, but that  
13                  usually occurs, as I said before, in the setting  
14                  where if there is continued inflammation that is  
15                  being suppressed by the steroids, the white blood  
16                  cell count is going to be elevated because the  
17                  steroids do the opposite in terms of release of  
18                  white cells from the marrow, release of the white  
19                  cells from the margination of the circulation and  
20                  they help the recruitment of polymorphonucleated  
21                  leukocytes. That is the usual picture one sees in  
22                  this setting.

23                  The usual reasons that an ID  
24                  consult is asked to see a patient such as this, did  
25                  not pertain in this case, that is the white count

1 was not elevated significantly, the patient's white  
2 count continued to fall several days after  
3 antibiotics were withdrawn.

4 Q. That didn't answer my question. I'm sorry,  
5 sometimes I don't ask great questions.

6 You said whether or not specific  
7 therapy would have prevented the event that took  
8 place is problematic and conjectural. I understand  
9 what you told me. That isn't what I believe this  
10 sentence was about.

11 Are you saying you have an opinion  
12 even if Dr. Sonpal I'm going state as early as  
13 January 14th would have given this woman a systemic  
14 antifungal, Fluconazole or something else, you  
15 don't think that had any chance whatsoever of  
16 preventing the Candida infection she had and died  
17 by?

18 A. Fluconazole is a drug that's active against  
19 many but not all Candida organisms. If you are  
20 going to treat a patient with maximal antifungal  
21 therapy you must take Amphotericin B which is toxic  
22 to the kidney, not something you use lightly.

23 Q. Let's say I agree with you, let's separate  
24 that out. I'm trying to get an answer to my  
25 question.

1       A.       I'm trying to answer your question.  You  
2       don't understand the complexity of the question you  
3       are asking.  It's simplistic to state that the  
4       outcome in this case would have been different if  
5       five antibiotics had been given instead of three.  
6       You are asking for additional antibiotics that  
7       would have been given for the yeast organism and  
8       Enterococcus simply because the three antibiotics  
9       she was receiving did not cover those particular  
10      organisms.

11                   It's a totally simplistic notion if  
12      you are going to give every patient who has stool  
13      cultured from an intraperitoneal location an  
14      antibiotic for every organism that you are going to  
15      grow from stool, this is stool, not pus, not  
16      infection, this was stool where it doesn't belong.

17                   As I pointed out in my letter, I  
18      believe that many surgeons do not culture fecal  
19      material because the results of treatment and the  
20      selection of antibiotics are just as effective as  
21      antibiotics selected on the basis of cultures.  I  
22      believe Dr. Frey has written on that as well.

23      Q.       Let me go back to ask you the question I'm  
24      trying to get answered.

25                   First of all let's start with you

1 know the Candida she grew out was Candida albicans,  
2 wasn't it?

3 A. Yes.

4 Q. Fluconazole would be effective against  
5 Candida albicans?

6 A. Not all strains.

7 Q. Generally speaking would it be effective?

8 A. No, generally speaking is not appropriate  
9 because we have no way of testing Candida in the  
10 microbiology laboratory for susceptibility to  
11 antibiotics.

12 This is an extremely important  
13 point you are obviously not qualified to render an  
14 opinion on that I'm attempting to explain it to  
15 you.

16 If you have a significant Candida  
17 infection, you use Fluconazole, 10 to 15 percent of  
18 Candida albicans may be resistant to that  
19 antibiotic. In a situation as critical as this  
20 lady was, to use a drug 10 or 15 percent shy of  
21 100 percent susceptibility would be shortchanging  
22 this patient. The only way to get a 100 percent  
23 certainty that Candida was being covered would be  
24 to give Amphotericin B which is a highly toxic  
25 drug.

1 Q. You said as critical as this lady was she  
2 would have been shortchanged. If someone called  
3 you, said as surgeons we want to cover for this  
4 Candida because of what we think might happen, what  
5 would you have told them to use?

6 A. If I felt she needed treatment for the  
7 Candida?

8 Q. Yes.

9 A. I would initiate Amphotericin B therapy.

10 Q. Back to the question I was trying to ask you,  
11 are you stating based on the sentence you put in  
12 the report, that whether it would have prevented  
13 the event that took place is problematic and  
14 conjectural, back to what you wrote in your report,  
15 what do you mean when you say that you don't  
16 believe there was coverage available for the  
17 Candida that could have controlled the fungus?

18 A. I'm saying to state that the use of those  
19 antibiotics would have made a difference in the  
20 ultimate outcome is purely conjectural.

21 All infections are associated with  
22 residual persistent organisms. The antibiotics  
23 handle the infection. A phenomenon that is common  
24 to all infection is the fact that you never, even  
25 with the most appropriate antibiotics, kill off all

1 the organisms that are the target of the  
2 antibiotic. There are always organisms left  
3 behind. They are dormant, they are sleeping, they  
4 are not active.

5 The body's scavenging system is  
6 responsible for cleaning up the debris over a  
7 period of weeks or even months.

8 Even if you had given antibiotics  
9 and you might have eliminated those organisms  
10 entirely, the fact 10 days after the antibiotics  
11 were stopped this woman suddenly crashed again is a  
12 very noteworthy event.

13 Had she had simmering small  
14 collections of fluid that were contaminated or  
15 infected with these organisms, she would have  
16 relapsed much more quickly, particularly being on  
17 steroids which interfere with the efficacy of host  
18 response.

19 Q. Do you believe the Candida Enterococcus are  
20 an aggressive organism or do they take some time to  
21 flourish so to speak?

22 A. Both.

23 Q. Explain your answer then.

24 A. Under certain circumstances they can be  
25 aggressive, under certain circumstances less

1 aggressive.

2 Q. What circumstances would make Candida  
3 aggressive?

4 A. Nobody knows that.

5 Q. So when you gave me that answer, was that  
6 what you are trying to say, you don't know?

7 A. No one knows that. You get positive blood  
8 cultures for Candida 24 hours after you inoculate  
9 blood in the blood culture bottles, sometimes it  
10 takes 10 days for the Candida to grow in the blood  
11 culture.

12 Q. In the literature it can take up to three  
13 weeks?

14 A. Some strains grow more slowly, much less  
15 aggressive in a blood culture media, equally less  
16 aggressive in the body.

17 The fact of the matter is you can  
18 take the most susceptible organism, the most potent  
19 antibiotic, have the patient recover from the  
20 infectious process, still have viable organisms  
21 resting in the damaged tissue. This has been  
22 demonstrated from the first day of antibiotic usage  
23 with Penicillin on Pneumococcus, Pneumococcal  
24 pneumonia. There is a persistent reproducible  
25 phenomenon of all infection.



1                   To believe that you would have  
2                   eliminated Candida entirely with Fluconazole or  
3                   Amphotericin or eliminated Enterococcus down to the  
4                   very last organisms if you had given Ampicillin and  
5                   Vancomycin is conjectural. There is no way to  
6                   know. All I know is what was in the chart.

7                   The chart clearly indicates that  
8                   the date -- that the five days between the 20th and  
9                   25th when blood counts were being obtained almost  
10                  on a daily basis this woman's white blood cell  
11                  count was going back toward normal despite being on  
12                  high doses of steroids.

13                  If she had a significant collection  
14                  of fluid in her abdominal cavity containing these  
15                  organisms she should have relapsed much more  
16                  quickly.

17                  A CT scan was done to look for an  
18                  accumulation of fluid. There was a thin layer of  
19                  fluid in several parts of the abdomen which you  
20                  would expect from someone who had all this fecal  
21                  material flowing into the peritoneal cavity 10 days  
22                  earlier. They went and looked for a collection,  
23                  they didn't find it.

24                  They cultured the wound which was  
25                  draining a little bit of fluid, asked Dr. Bass to

1     come in and evaluate the results of those cultures,  
2     he again found two organisms that are consistently  
3     found in the wounds or secretions of patients on  
4     massive doses of antibiotics.

5             The Enterococcus and Candida --  
6     you've been reading about Vancomycin resistant  
7     Enterococcus, the reason Vancomycin resistant  
8     Enterococcus is the new boy on the block is because  
9     of all the antibiotics that are being used,  
10    particularly Cephalosporin that encourage an  
11    overgrowth of Enterococcus at the expense of other  
12    organisms.

13            Dr. Bass mentioned this I believe  
14    in his note he was concerned in this particular  
15    patient about throwing yet more antibiotics at this  
16    patient who needed an opportunity to recover from  
17    the effects of antibiotics. Many times we stop  
18    antibiotics because we want the amorphal bacterial  
19    flora to reassert itself in situations such as  
20    this.

21            We don't have good markers for  
22    this. We have to go by the tools that are  
23    available and Dr. Bass made an extremely judgmental  
24    decision on the day he saw this patient based on  
25    the database he accumulated at that time.

1                   He was concerned for example about  
2                   the urinary tract because she had Candida in the  
3                   Foley catheter. He followed the union rules, got  
4                   another urine because the Foley catheter had been  
5                   removed, he knew that if the Foley catheter was  
6                   out, Candida still persisted in the bladder, that  
7                   needed treatment.

8                   Candida in the bladder is a  
9                   sequestered area, as opposed to Candida in the  
10                  wound which is not a sequestered area, can be  
11                  treated with good wound care.

12                  You can't give an antibiotic for  
13                  everything cultured in a wound down in this area  
14                  because we know certain organisms are colonizers,  
15                  commensals, they are along for the ride, not  
16                  causing any trouble.

17                  If your wound is not healing, then  
18                  withholding antibiotics is a serious matter. This  
19                  wound was healing. He specifically describes good  
20                  granulation tissue in the wound and healing process  
21                  in the face of large doses of steroids, which  
22                  normally interfere with the healing process.

23                  I don't see what else Dr. Bass  
24                  could have done at that point in time except to do  
25                  exactly what he did. He went looking for trouble,

1 found that the urine was now clear of Candida,  
2 therefore did not require any treatment, made an  
3 appropriate judgment on the status of the wound and  
4 the organisms that were growing there, two  
5 survivors of these telltale organisms for the  
6 antibiotics on board, that is exactly what was  
7 happening here.

8 Q. Do you agree with Dr. Bass' testimony from  
9 his deposition that the existence or nonexistence  
10 of Candida in the wound does not tell you what is  
11 going on in the abdomen itself?

12 A. Exactly.

13 Q. Fair enough.

14 Back to your report, as I'm still  
15 trying to understand what you were trying to  
16 express, you will be expressing at trial, focusing  
17 on the following sentence, "The fact of the matter  
18 is there is certain minimal incidence of 5 to  
19 10 percent of morbidity and mortality from  
20 intra-abdominal infections of this severe nature."

21 I want to take that sentence, see  
22 what you mean. Do you mean there is a minimal  
23 incidence of 5 to 10 percent of M&M from Candida  
24 and Enterococcus?

25 A. Not specifically those two.

1 Q. What were you referring to when you wrote  
2 that sentence?

3 A. That 5 to 10 percent of patients either die  
4 or have complications following fecal soilage of  
5 the intraperitoneal cavity, regardless of their  
6 clinical status or variables thereof.

7 This is a significantly serious  
8 disease even under the best of circumstances in  
9 terms of getting to the patient quickly, cleaning  
10 out the intra-abdominal fecal soilage as promptly  
11 and thoroughly as possible. You are going to have  
12 problems 5 to 10 percent of the time.

13 Q. That was the question I want to ask. You  
14 weren't limiting this to Enterococcus and Candida,  
15 you are saying anyone that has an intra-abdominal  
16 catastrophe of this nature, even with an  
17 appropriate treatment, coverage for pathogens,  
18 there is a small risk that they might die anyway?

19 A. The signal word that you use is catastrophe.  
20 This is as catastrophic as it gets.

21 Q. That's what I'm trying to determine. It's  
22 your contention then a 5 to 10 percent morbidity?

23 A. Not my contention. That is what the  
24 literature shows when you have a perforated colon,  
25 you have feces in the intraperitoneal cavity, that

1 despite the best of care there is a going to be a  
2 significant morbidity and mortality which depends  
3 on how quickly you get in there, how easy it is to  
4 resect the perforated area, how efficiently you  
5 mechanically remove the fecal material, how long  
6 the patient is under anesthesia, the age of the  
7 patient, whether they can tolerate the systemic  
8 effects of absorbing all the toxins from the  
9 peritoneal cavity.

10 The peritoneal cavity has one of  
11 the most efficient means for absorbing toxins. You  
12 can get in there 10 minutes after the fact, the  
13 peritoneal cavity absorbs the toxins, that patient  
14 is going to have trouble no matter how effectively  
15 you remove the material mechanically, how  
16 aggressively you use antibiotics, et cetera.

17 Q. I am trying to see what you meant by that.

18 From your review of the chart, do  
19 you agree that Carolyn's temperature began to rise  
20 after the antibiotics were withdrawn?

21 A. I don't recall that specifically. She had on  
22 several days had a couple of low grade temperature  
23 elevations.

24 Q. It just is not committed in your memory well  
25 enough to state whether or not that is accurate,

1 her temperature started to rise after she was taken  
2 off her antibiotics?

3 A. Well as I said I didn't graph it out there.  
4 I commented that there was --

5 Q. Fluctuations?

6 A. -- fluctuations of a low grade temperature.  
7 You can have a significant temperature disturbance  
8 without ever having numbers above what is  
9 considered to be normal. If there is a variation  
10 within a 24 hour period of more than one degree in  
11 that 24 hour period you can have a significant  
12 temperature problem down around 97, 98.

13 Q. Clinically what does that mean if the person  
14 has been on antibiotics for 10 days, they are  
15 withdrawn from antibiotics, they begin to  
16 experience some increases in temperature above 100,  
17 what would that suggest to you?

18 A. Often a rebound phenomenon when we stop the  
19 antibiotics.

20 Q. What is a rebound phenomenon?

21 A. Antibiotics are holding things in check, the  
22 body now has to fight the inflammatory process,  
23 infection on its own. It gears up the cytokines  
24 and other inflammatory factors. In addition to  
25 fighting infection, may be pyrogenic.

1 Q. When Carolyn was first admitted to the  
2 hospital I believe you'll agree with me, wouldn't  
3 have to look it up, she was placed empirically on  
4 antibiotics for the contamination in her abdomen,  
5 correct?

6 A. Correct.

7 Q. I think Gentamycin, Cefotetan and Flagyl?

8 A. Correct.

9 Q. Probably a soup, a pretty common I would  
10 suspect empiric coverage?

11 A. I wouldn't use the word common.

12 Q. They didn't have anything to go on on the day  
13 she was admitted what they might be covering for?

14 A. I disagree with you. When you've got the  
15 stool in the peritoneal cavity, you cover for  
16 anaerobes with Flagyl; gram negatives with  
17 Gentamycin. You need to cover for gram positive,  
18 Cefotetan covers for gram positive, also a little  
19 bit of a bonus in that you get additional anaerobic  
20 done under Cefotetan. It's a combination that  
21 cannot be either endorsed or reproached. Not an  
22 unreasonable selection of antibiotics. It doesn't  
23 cover everything that might be in stool.

24 Q. I wasn't suggesting that it was unreasonable  
25 when I said it was common. What I mean is in the



1 face of this kind of abdominal event, that would be  
2 an expected regimen to institute without knowing  
3 what is there?

4 A. I would use the word accepted.

5 Q. Accepted is fine with me.

6 A. Not necessarily the best combination.

7 Q. That is probably a fair assertion also.

8 By the 14th of January she has been  
9 on those antibiotics for about four days I suppose,  
10 that is when the cultures came out; does that  
11 comport with your recollection?

12 A. Roughly.

13 Q. What is your recollection of her body's  
14 response both temperature wise, white blood count  
15 wise to the initial empiric antibiotic regimen?

16 A. She was improving.

17 Q. In what way was she improving?

18 A. She was alive.

19 Q. That's good.

20 A. There were no signs of intraperitoneal  
21 inflammation, her physical findings were  
22 decreasing. She still had some temperature, that  
23 is not necessarily a bad sign.

24 Q. Do you have a recollection of whether her  
25 white blood count continued to climb after the

1 fourth day?

2 A. The white blood count in a patient on  
3 steroids is very difficult to interpret, whether it  
4 was going up, or coming down, or staying the same.  
5 It's just one piece of the database.

6 The white blood cell count is a  
7 very crude and inaccurate reflection of the body's  
8 defense mechanism. As I tried to point out before,  
9 it's a snapshot of a dynamic process, depends on  
10 when you take the snapshot, early, middle or late  
11 in the surgery or message to the marrow or the  
12 storage area in the blood stream. If you take the  
13 same tests several times a day you might get  
14 several different answers because of the dynamics  
15 of the process.

16 Q. But the doctors didn't do that several times  
17 a day, did it once a day, tend to rely on the  
18 trends; wouldn't you agree with that?

19 A. Yes.

20 Q. That is what most doctors do?

21 A. You can't order blood tests three times a  
22 day, you'll deplete the patient of their blood.

23 Q. Absolutely.

24 You also wrote in your report that  
25 her intraperitoneal space had been contaminated

1 with these organisms. You are referring to  
2 Enterococcus and Candida besides other factors that  
3 may well have entered into the situation subsequent  
4 to readmission to re-energize organisms; do you  
5 recall writing that?

6 A. Yes.

7 Q. Let's talk about what do you think  
8 re-energized those organisms, if anything?

9 A. What I'm interested with is the fact this  
10 woman is almost 10 days after antibiotics before  
11 she crashed. If she has little collections of pus  
12 simmering and stewing inside little folds of her  
13 bowel or peritoneal lining, why did it take so long  
14 for them to wake up and cause trouble?  
15 Particularly in the presence of steroids, which  
16 interfere with host defenses normally.

17 A patient who has got an abscess or  
18 collection of material that needs attention is  
19 going to relapse much more quickly than this. Is  
20 going to do so in the setting of a white cell  
21 elevation or persistent increase, which she did not  
22 demonstrate.

23 Q. My question is: What do you believe, based  
24 upon your review of the chart, happened to  
25 re-energize these organisms?

1 A. I have no idea. No one can have any idea.

2 Q. Do you have any possible suggestions you are  
3 willing to offer?

4 A. At autopsy there was evidence of the  
5 possibility of insufficient blood supply to the  
6 intestines. Again that may be cause, may be  
7 effect. I have no idea.

8 She had Enterococci in her urine I  
9 believe at the time she re-entered the hospital.  
10 She could have had an Enterococcal urinary  
11 infection.

12 Q. Can you explain the subdiaphragmatic  
13 abscesses of about 10 centimeters found at autopsy  
14 that contained Candida fungus?

15 A. You want me to explain them?

16 Q. Um-hum.

17 A. She had soilage of her intraperitoneal cavity  
18 some weeks earlier with stool, which normally  
19 contains small numbers of yeast and moderate  
20 numbers of Enterococci. These are the hardy  
21 survivors of her original contamination.

22 Q. What caused her GI bleed?

23 A. I have no idea.

24 Q. Are you sufficiently trained to determine  
25 whether the transmural mucosal ischemia seen at

1 autopsy was a cause or effect of her sepsis?

2 A. No one can tell you whether it was cause or  
3 effect.

4 Q. Why would you say there is no one?

5 A. No one can say it caused it or was an effect  
6 of the final septic picture she had.

7 Q. Why can't anyone tell me that?

8 A. You don't know the time sequence.

9 Q. Is there some sort of pathological evidence  
10 that would tend to support one conclusion greater  
11 than the other in your opinion?

12 A. If she had a chronic vascular insufficiency  
13 you might have expected something catastrophic to  
14 happen a little earlier.

15 On the other hand, if she had a  
16 hidden subdiaphragmatic abscess that needed to be  
17 discovered and attended to earlier on, then at the  
18 10 or 11 days when it broke loose and caused  
19 trouble you need some evidence, some indication to  
20 go back and restudy that patient.

21 If she had another CT scan 12 hours  
22 before she crashed would she have lived despite the  
23 circumstances that eventuated, I have no way of  
24 knowing. No one has any way of knowing.

25 If she had dormant organisms

1 slumbering in little bits of fluid, she had these  
2 many days when she was in the hospital, then at the  
3 nursing home, they suddenly woke up, started to  
4 multiply frantically, caused the larger  
5 accumulation under the diaphragm found at autopsy,  
6 then obviously getting rid of them earlier might  
7 have made a difference.

8                   On the other hand these could be  
9 normal persisting. You want it both ways. You  
10 want from the time of the original colectomy,  
11 discovery of the perforation and fecal contaminated  
12 peritoneal cavity until the time she experiences  
13 this was about three weeks. Those organisms were  
14 not treated at any time during those three weeks.  
15 Why did it take three weeks for them to rev up and  
16 get her into trouble?

17                   Obviously something that had been  
18 done to this lady prior to that catastrophic event  
19 was very right and real, very effective. There is  
20 no way to know why it took three full weeks for  
21 those two organisms to declare themselves as an  
22 enemy and produce the fatal outcome they did. It's  
23 really three weeks that those organisms were there,  
24 not treated in a woman on massive doses of  
25 steroids, which further immunocompromises her, why

1 did it take three weeks for the process to evolve  
2 and suddenly explode in the way it did on the  
3 20th. Halfway between those three weeks they did a  
4 CT scan that did not reveal those subdiaphragmatic  
5 fluid collections.

6 Q. Have you seen that CT scan by the way?

7 A. No, I haven't.

8 Q. Would you agree if testimony was offered in  
9 this case that the use of corticosteroids itself  
10 will -- I'm trying to think of a good word for  
11 it -- delay the formation of an identifiable  
12 abscess in the abdomen?

13 A. Absolutely. It's part of its  
14 anti-inflammatory property.

15 Q. You've not read Dr. Frey's report of course?

16 A. No.

17 Q. Assuming that he says what he says in his  
18 report, if he concludes that an autopsy  
19 demonstrated that Mr. Yarborough died of  
20 intra-abdominal abscess, are you going to be  
21 disputing his opinion on that?

22 A. There is no way to dispute that.

23 Q. He also states that Mrs. Yarborough died as a  
24 result of her severe immunosuppression from her  
25 underlying illness and therapy?

1 A. There is no question steroids played a role  
2 in this case.

3 Q. I'm going to ask you some general medical  
4 questions, give you some statements, see what you  
5 agree or disagree with that I say, okay?

6 A. Okay.

7 Q. Do you know what fungal translocation is?

8 A. Fungal translocation is?

9 Q. Is that a concept you're familiar with?

10 A. Translocation is a general phenomenon, not  
11 limited just to fungal. Bacteria and other  
12 organisms in the lumen of the intestine can escape  
13 through the wall of the intestine when the  
14 integrity of the intestinal wall is compromised.

15 Q. Specifically are you acquainted with fungal  
16 translocation and what certain circumstances in any  
17 individual increases that phenomenon?

18 A. The phenomenon of translocation is a general  
19 one in which the integrity, the anatomic integrity  
20 of the lumen of the intestine is compromised so the  
21 organisms inside the lumen can be transported  
22 outside the lumen without there being a gross  
23 opening or defect.

24 Q. In other words it's more or less the passage  
25 of fungus into extra-intestinal sites, we will



1 start with that simple definition?

2 A. Extra-intestinal sites through the blood  
3 stream. Has nothing to do with this case.

4 Q. Do you agree or disagree immunosuppression of  
5 a host increases that opportunity?

6 A. No.

7 Q. You do not agree?

8 A. No.

9 Q. You obviously agree that physical disruption  
10 of the intestinal tract is going to contribute to  
11 that phenomenon, that is what you just told me,  
12 right?

13 A. No, I said that -- you asked two separate  
14 questions.

15 Q. Go ahead. So you don't think that disruption  
16 of the intestine has anything to do with transport  
17 of fungus into areas, other areas in the body?

18 A. Well now you keep asking it as a  
19 nonquestion.

20 Translocation is the escape of  
21 organisms from the lumen of the intestinal tract to  
22 intra-abdominal foci because there is a compromise  
23 and loss of integrity of the wall of the bowel.  
24 This can result from organisms finding their way  
25 into the blood vessels that supplied the intestine,

1 they can traverse the intestinal lumen, be  
2 extraluminal.

3 The fact that the patient is on  
4 steroids doesn't necessarily increase or decrease  
5 that likelihood unless you have offensive steroids  
6 on the integrity of the lumen of the bowel itself.

7 Q. Do you agree or disagree with the following:  
8 Candida organisms are frequently cultured, but  
9 intra-abdominal infection should only be considered  
10 as a serious threat in a high risk patient?

11 A. No, I don't agree with that.

12 Q. Which part don't you agree with?

13 A. Should only be considered a threat in a high  
14 risk patient. They should be considered as a  
15 threat in every patient and evaluated accordingly  
16 on an individual basis.

17 Q. And empirically treated to prevent a person  
18 from developing a massive Candida infection?

19 A. The point I tried to make repeatedly it's a  
20 common finding in intra-abdominal infection to  
21 recover Candida organisms from the cultures. It is  
22 not necessary or necessarily recommended to give a  
23 specific antibiotic for that organism in every  
24 instance.

25 We have done this ourselves, in one

1 particular instance a very good friend of mine had  
2 this organism growing from his polymicrobial  
3 infection. We withheld antifungal therapy because  
4 it would have been the fifth or sixth antibiotic to  
5 give the man, Amphotericin, his kidneys were  
6 already in trouble. He did perfectly well.

7 Q. Were Carolyn Yarborough's kidneys in trouble  
8 when she was hospitalized at Saint Luke's from the  
9 9th to the 25th?

10 A. I don't recall.

11 Q. I'm going to read you the following  
12 statement.

13 MR. GOLDWASSER: What are you  
14 reading from?

15 MISS KOLIS: Reading medical  
16 statements.

17 MR. GOLDWASSER: Where are you  
18 reading from, it looks like an article.

19 MISS KOLIS: Sure. Reading  
20 from Dr. Solomkin's article on Candida.

21 THE WITNESS: An article, not  
22 the article.

23 Q. I'm reading an article. I asked if you had  
24 read any articles, you said no, you wrote to him.

25 A. Right.

1 Q. I'm going to ask you a couple questions. So  
2 that Mr. Goldwasser can find them, it is Dr. Frey's  
3 book Surgical Infection, chapter 62.

4 MR. GOLDWASSER: The author is  
5 doctor who?

6 MISS KOLIS: I can't  
7 pronounce it quite as gracefully as Dr. Lerner,  
8 Joseph S. Solomkin, University of Cincinnati I  
9 think, they don't give his credit.

10 Q. Let me read this to you: "Candida organisms  
11 are frequently cultured from the intra-abdominal  
12 infectious foci but should be considered as a  
13 serious threat only in high risk patients. The  
14 definition of high risk generally encompasses  
15 patients with antecedent episodes of sepsis or  
16 those who received immunosuppressive therapy. Such  
17 patients should receive systemic antifungal  
18 therapy."

19 In isolation what do you find wrong  
20 with that assertion?

21 A. I don't find anything wrong with it.

22 Q. Carolyn Yarborough was the classic high risk  
23 patient because of immunosuppressive therapy?

24 A. He didn't say every patient in that category  
25 deserves treatment. He's pointing the direction.

1 Every case is evaluated separately. Every case has  
2 a different set of situations, frame of reference,  
3 he's giving you a general guideline.

4 Q. Do you think that when he says such patients  
5 should receive systemic antifungal therapy that is  
6 like maybe you should, maybe you shouldn't?

7 A. He's recommending a generalization for when  
8 you consider the treatment of Candida in this  
9 setting.

10 MR. GOLDWASSER: Can I see that  
11 article?

12 MISS KOLIS: Absolutely.  
13 I'll make you a copy of it if you would like one.  
14 Otherwise I suppose you have Dr. Frey's book.

15 Q. Do you acknowledge that Candida is a problem  
16 in a person who has been on steroids?

17 A. Steroids are one of the reasons that Candida  
18 can cause more trouble than it usually does.

19 Q. There is a problem with overgrowth of  
20 Candida?

21 A. As I pointed out before antibiotics knock out  
22 more susceptible bacteria. The resistant Candida  
23 is a survivor in this setting. In patients who are  
24 intubated, on respirators, have been treated with  
25 antibiotics for pneumonia or other reasons, the

1 most common organisms in their respiratory  
2 secretion is Candida albicans and we never treat  
3 it.

4 MR. GOLDWASSER: Did you read  
5 the fact that it's controversial in the medical  
6 community?

7 MISS KOLIS: Depends on what  
8 circumstances you are reading. You get to ask my  
9 expert those questions, I'm sure.

10 Q. Doctor, I have a couple more questions for  
11 you.

12 Have you ever treated a person who  
13 has presented at any facility with an  
14 intra-abdominal catastrophe for the Candida found  
15 at the time?

16 A. Have I ever treated someone?

17 Q. Yes.

18 A. Of course I have.

19 Q. What circumstance would make you believe you  
20 should use an antifungal for a person who has  
21 cultured the same out of their abdomen?

22 A. I evaluate the patient, the patient's  
23 database, see whether that particular patient  
24 requires the addition of antifungal agents.

25 Fortunately in recent years the

1 availability of Fluconazole and other immuno  
2 antibiotics made it a little easier if are you not  
3 dealing with critical patients. An 85 percent  
4 chance of being right with a nontoxic drug is a lot  
5 more reasonable than a 100 percent chance of being  
6 right with a toxic drug such as Amphotericin.

7 Q. Let me ask you this question: If we both  
8 know and acknowledge that the Candida is a problem  
9 intra-abdominally in a person with steroids, what  
10 gives the person a better chance, no treatment at  
11 all with Candida or a treatment with something that  
12 gives an 85 percent chance of possibly dealing with  
13 the organisms?

14 A. Now you are mixing my response.

15 The 85 percent reply relates to the  
16 use of Diflucan, not Amphotericin. Amphotericin is  
17 still the Gold Standard in this setting because the  
18 fact we can't test the organisms in our  
19 laboratories, we have to make educated guesses for  
20 example in central line sepsis, where we can remove  
21 the central I.V. catheter in a patient who may be  
22 desperately ill, has Candida in the blood stream,  
23 remove the catheter, start them on Diflucan works  
24 better than a Candida infection in other situations  
25 where you can't remove the source of the Candida.

1                   The 10 or 15 percent discrepancy  
2                   doesn't matter as much if are you getting rid of  
3                   the source. Candida infection in every part of the  
4                   body is a little bit different than elsewhere.

5                   The fact of the matter is  
6                   intra-abdominal infection with polymicrobial  
7                   organisms, including Candida, remains a  
8                   controversial area. One in which there is no  
9                   100 percent correct answer to the question must you  
10                  treat, if you treat would the outcome be  
11                  different.

12                  This particular case is not unique,  
13                  but unique enough in its database to raise the  
14                  question seriously was this patient treated  
15                  properly by withholding specific antifungals or  
16                  antiyeast therapy. My contention is at the time  
17                  these questions were asked and at the time the  
18                  patient was evaluated and the database involved,  
19                  the response in each instance was appropriate to  
20                  the database at a given point in time.

21                  Now if Dr. Bass had seen this lady  
22                  a week earlier when her white count was still  
23                  elevated, still running fever, he knew the results  
24                  of intra-abdominal cultures, then at that point in  
25                  time it's a whole different scenario, a whole



1 different database. He didn't see -- he saw her on  
2 the 23rd, more than a week after those results  
3 became available.

4 Q. How about Dr. Sonpal who did see her a week  
5 earlier with a different basis, you said it would  
6 be a whole different ball game, you want to tell me  
7 about that?

8 A. Yes. Dr. Sonpal was a surgeon who evaluated  
9 the surgical event that had taken place in this  
10 lady four days earlier. From a surgical point of  
11 view she was doing perfectly well, there was no  
12 reason to expect or be concerned about the fact  
13 that she still had fever, she still had the  
14 leukocytosis. His incision was healing, his wound  
15 was doing well, she was not in septic shock, she  
16 was doing very well for a patient with massive  
17 fecal contamination four or five days earlier on  
18 high dose steroids.

19 To have given another antibiotic  
20 based on the culture results that came back would  
21 have been inappropriate because unless you switch  
22 to antibiotics like a broad spectrum Cephalosporin,  
23 broad spectrum Cephalosporins are third generation  
24 Penicillin, then you would have ended up with five  
25 different antibiotics.

1                    Couldn't stop the Flagyl, you need  
2                    the anaerobic coverage. The Gentamycin was  
3                    potentially expendable, you had not grown an  
4                    organism based on that antibiotic being used.

5                    To change antibiotics based on the  
6                    culture results in a patient who is responding to  
7                    the therapy four days after surgery would have been  
8                    an irresponsible situation.

9                    If she was still systemically  
10                    compromised, not making urine adequately or was  
11                    hypotensive, or was showing signs of renal failure  
12                    or deterioration or blood gas problems, to have  
13                    ignored those organisms would have been  
14                    inappropriate. None of that was happening.

15                    Q.        Let me ask you this, Doctor, in fact you have  
16                    to take my word for it, challenge me to prove it at  
17                    trial I suppose: By the 14th of January when the  
18                    culture results came out, her white blood counts  
19                    were increasing, hypothetically, assume this.

20                    MR. GOLDWASSER:        Why don't we  
21                    look at the record.

22                    Q.        Look at the chart if you like to.

23                    MR. GOLDWASSER:        Here, the 14th.

24                    Q.        Look on the 14th. What was the white blood  
25                    count on the 14th?

1 A. 19,000.

2 Q. What was it on the 15th?

3 A. The same, 20,000, that is the same number.

4 Q. The 16th, was it elevated?

5 A. 26,000.

6 Q. Stop right there. Look, you are using the  
7 word database, I'm assuming that is a database?

8 A. On the 17th down to 17,000, the next day it's  
9 bouncing around in the same area. This is not a  
10 white count to alarm anybody. These are all  
11 similar white counts, 20,000, 19,000, 18,000,  
12 17,000, I can't emphasize how many times I've said  
13 to you, you are taking a snapshot of a dynamic  
14 process. These little changes in numbers don't  
15 mean a damn thing. They are totally  
16 insignificant.

17 You've got a lady on steroids who  
18 has got a white count with the exception of the one  
19 on the 16th where you have 26,000, you have  
20 essentially the same white count on the 14th, 15th,  
21 17th, 18th, 19th, and 20th. And the 21st for that  
22 matter. This is not a problem in a lady who  
23 recently had massive fecal contamination of her  
24 peritoneal cavity, who is getting steroids. My  
25 God, I would be delighted to have a white count in

1 that range. You have to understand that  
2 antibiotics do not -- they are not  
3 anti-inflammatory, they are not antipyretic, they  
4 are there to prevent bacteria from multiplying,  
5 producing further damage.

6 At any point in time where you  
7 intervene with antibiotics, depending on how much  
8 inflammation damage has been done by the  
9 multiplying bacteria, that is how long it takes to  
10 bring things under control.

11 If you get in there quickly, you  
12 may get a more rapid response. If you get in there  
13 a little bit late, there is inflammation that the  
14 body has to take care of.

15 This lady was doing a fine job  
16 despite the massive doses of steroids. Her host  
17 response was doing very, very nicely. The proof of  
18 the pudding was her white blood cell count the day  
19 she stopped the antibiotics was 20,000 -- was  
20 20,360; the next day 19,720; the 22nd it was  
21 19,690; on the 23rd, 13,024; 24th, 12,000; on the  
22 25th it was 11,000. Going exactly where it was  
23 supposed to be going.

24 The doctors that took care of this  
25 lady were following her carefully, everything was

1 moving in a positive direction. She didn't become  
2 afebrile overnight. She wouldn't return to normal  
3 overnight. She suffered a massive insult to her  
4 system. The fact that she continued to run a low  
5 grade fever was an indication of the severity of  
6 that inflammatory insult.

7 Q. Do you think she was still infected when she  
8 left the hospital?

9 A. What is your definition of infected?

10 Q. What is yours?

11 A. I know what mine is, you are the one asking  
12 the question.

13 Q. Was Carolyn still fighting off bacterial or  
14 fungal infection when she was discharged on  
15 the 24th?

16 A. Did she have an actively multiplying Candida  
17 and Enterococcus on the day after discharge?

18 Q. Yes.

19 A. No, she had dormant organisms in there.

20 Q. How do you conclude the organisms were  
21 dormant on that day?

22 A. She was in no position to defend herself  
23 against an abscess with these organisms in the  
24 absence of antibiotics and go to a nursing home for  
25 four days before she crashed.

1 Q. How does the abscess develop?

2 A. How does the abscess develop?

3 Q. Um-hum.

4 A. It developed in a normal fashion after  
5 damage, injury and tissue response.

6 Q. How long does it take an abscess of the size  
7 found at autopsy to develop?

8 A. I have no idea how long it took to develop.  
9 I can tell you it wasn't that size, wasn't present  
10 on the 25th. I can tell you that with a reasonable  
11 degree of certainty. I can tell you somewhere  
12 along the line between the 25th and the 30th when  
13 she came in and crashed --

14 Q. Correct.

15 A. That this organism suddenly woke up from a  
16 slumber if it was there at the time, provoked an  
17 acute and serious inflammatory response on the part  
18 of the host.

19 I can also tell you again with a  
20 reasonable degree of certainty if a small abscess  
21 had been present at the time of discharge, Dr. Bass  
22 saw her, she wouldn't have the luxury of four days  
23 in a nursing home when she crashed. A compromised  
24 patient with impaired host defenses, if she had a  
25 dormant abscess it would have exploded much

1 earlier.

2 Q. Do you have an opinion you will be rendering  
3 at trial whether or not anything the nursing home  
4 did during the five days between discharge and  
5 admission to Huron Road Hospital caused or  
6 contributed to cause her demise?

7 A. I have no opinion.

8 Q. Did Mrs. Yarborough do anything herself to  
9 cause her own demise?

10 A. There is no way of saying that.

11 MR. GOLDWASSER: We're not  
12 claiming that.

13 MISS KOLIS: Doctor, I don't  
14 have any further questions. Thanks.

15

16

17

18 (Deposition concluded; signature not waived.)

19

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ERRATA SHEETNOTATIONPAGE/LINE

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I have read the foregoing  
transcript and the same is true and accurate.

-----  
PHILLIP LERNER, M.D.



1 The State of Ohio, :

2 County of Cuyahoga. : CERTIFICATE:

3 I, Constance Campbell, Notary Public within  
4 and for the State of Ohio, do hereby certify that  
5 the within named witness, PHILLIP LERNER, M.D. was  
6 by me first duly sworn to testify the truth in the  
7 cause aforesaid; that the testimony then given was  
8 reduced by me to stenotypy in the presence of said  
9 witness, subsequently transcribed onto a computer  
10 under my direction, and that the foregoing is a  
11 true and correct transcript of the testimony so  
12 given as aforesaid.

13 I do further certify that this deposition was  
14 taken at the time and place as specified in the  
15 foregoing caption, and that I am not a relative,  
16 counsel or attorney of either party, or otherwise  
17 interested in the outcome of this action.

18 IN WITNESS WHEREOF, I have hereunto set my  
19 hand and affixed my seal of office at Cleveland,  
20 Ohio, this 1st day of July, 1998.

21   
22 -----

23 Constance Campbell, Stenographic Reporter,  
24 Notary Public/State of Ohio.

25 Commission expiration: January 14, 2003.

**Look-See Concordance Report**

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 UNIQUE WORDS: **1,523**  
 TOTAL OCCURRENCES: **4,224**  
 NOISE WORDS: **385**  
 TOTAL WORDS IN FILE: **12,140**

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 SINGLE FILE CONCORDANCE

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 CASE SENSITIVE

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 PHRASE WORD LIST(S):

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 NOISE WORD LIST(S): **NOISE.NOI**

---  
 COVER PAGES = 4

---  
 INCLUDES ONLY TEXT OF:

**QUESTIONS**  
**ANSWERS**  
**COLLOQUY**  
**PARENTHETICALS**  
**EXHIBITS**

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 DATES ON

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 INCLUDES PURE NUMBERS

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 POSSESSIVE FORMS ON

---  
 MAXIMUM TRACKED OCCURRENCE  
 THRESHOLD: **50**

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 NUMBER OF WORDS SURPASSING  
 OCCURRENCE THRESHOLD: 1

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 LIST OF THRESHOLD WORDS:

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 Candida [58]

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