#634

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

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IN THE COURT OF COMMON PLEAS

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ARAZINE SMITH, executrix of the ESTATE of CAROLYN YARBOROUGH, plaintiff, :
vs. : Case No. 326850
SAINT LUKE'S HOSPITAL, defendant. :

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

APPEARANCES:

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# I N D E X

WITNESS: PHILLIP LERNER, M.D.



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(NO EXHIBITS MARKED)

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(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

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PHILLIP LERNER, M.D.

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

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

MR. GOLDWASSER: Now he does.

MISS KOLIS: The answer is yes. Absolutely.

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CROSS-EXAMINATION

BY MISS KOLIS:

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

A. Phillip I. Learner. My professional address

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

Q. I appreciate that.

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

A. Yes, this is it.

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

Are you Boarded?

A. No.

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

A. Correct.

Q. Fair enough, thank you very much.

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

A. Yes and no.
Q. Can you explain your answer for me?
A. Some of the papers, review papers on the various Streptococcal infections that our group in Cleveland reported probably included cases wherein Enterococcus and yeast were involved, they weren't a major part of the paper.
Q. I guess I would be fairly certain if I went to the library, if I had the time, and pulled every article, I'm not going to find you have written anything specifically directing itself to the issue of when you do or don't cover for those organisms; that's a fair statement?
A. Okay.
Q. I don't want to put words in your mouth, I'm checking to see if you feel anything contained in your CV is fact specific to this case?
A. I would say no.
Q. I gather, based upon my own investigation, this is not the first time you've appeared as an expert witness?
A. Correct.
Q. Doctor, have you testified on behalf of a patient in the past?
A. Yes.

Q. About how many times?
A. It's 60/40.
Q. Fair enough. I didn't know, I don't have all that data available.
MR. GOLDWASSER: 60/40 for plaintiffs?
THE WITNESS: No, 60/40 for defense.
Q. The cases that you've been asked to testify for on behalf of the patient, were those cases where you were involved as a subsequent treating physician, or just simply cases that you were contacted by plaintiffs' attorneys?
A. To the best of my recollection I have had only one case in which I was personally involved as a treating physician.
Q. When was the last time you testified in court on behalf of a plaintiff?
A. It's hard to say. I really don't keep track of that. I would say probably about two years ago.
Q. Can you tell me what attorney that was you testified for?
A. I would have to look it up.
Q. Without belaboring things I have to cover these issues, I did a docket search in Cuyahoga

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

A. No, only one lawsuit went through.

Q. Let me ask my question better.

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

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

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

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

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

A. Zero.

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

MR. GOLDWASSER: She is the plaintiff?

MISS KOLIS: Yes.

MR. GOLDWASSER: Catherine Crouse?

A. There was a house officer who sued.

Q. Yourself and the hospital?

A. That was dismissed years ago.

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

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

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

A. It was thrown out.

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

A. 25 years.

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

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

MR. GOLDWASSER: Talking about quality assurance committee?

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

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

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

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

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

particular cases in the hospital?
A. Well, again, there is no -- there is a -- for years I was on the surgical evaluation committee. This was the -- what was it called. I can't remember the name of the committee. I was a member of the committee that reviewed surgical performance, not just from infection control, a variety of situations.

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

Q. Fair enough answer.

I assume that you are going to charge me for the time we spend together today?
A. It's delightful to be with you, but it's going to cost you.
Q. Can you tell me what you will be charging me

an hour for testimony today?

A. $300.

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

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

Q. Of course.

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

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

Candida is an organism that is

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

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

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

Have you been able to read his publication on Candida?

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

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

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

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

Q. We will ask you some medical questions later.

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

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

Q. Fair enough.

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

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

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

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

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

A. I might if it's necessary.

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

A. I'd be happy to do that.

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

A. I always come without a file.

Q. Good enough. Makes it easier I suppose.

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

A. Yes.

Q. First line says that?

A. Yes.
Q. Your report is dated May 29th. I want to cover some of the basics.
It says that you have reviewed the materials forwarded, listed as six items. Can you tell me, Doctor, from your memory or with coaching from Mr. Goldwasser, what six items you reviewed in reaching your opinions in this matter?
A. Without having his cover letter I would --
MR. GOLDWASSER: I don't have my file with me. I know I sent you the deposition of Dr. Bass.
A. Dr. Bass' deposition, the two confinements.
Q. At Saint Luke's?
MR. GOLDWASSER: Sent you the expert reports, I believe.
A. The two expert reports subsequently were sent to me separately.
MR. GOLDWASSER: Right. Meridia Huron Road record.
A. Meridia Huron Road record and the nursing home records.
Q. Since that time obviously your report also reflected did you receive the reports of my experts, Dr. Holzman and Dr. Chung?

A. Yes.
Q. Have you also received a rather large quantity of additional medical records that predated this particular confinement, the Saint Luke's confinement? Mr. Goldwasser was shaking his head.
MR. GOLDWASSER: We didn't send them to him. The only thing I sent him recently was the Candlewood Nursing Home records during that four, five days before she crashed.
Q. Would you have had the Candlewood Nursing Home record before you prepared this report; am I stating that accurately?
A. No, I got those records after the report.
MR. GOLDWASSER: I just sent it to him recently.
Q. Have you had an opportunity to review those records?
A. Yes, I did.
Q. Anything contained in those records affect opinions that you've set forth in your report?
A. Only that my opinion or what I could glean from the record suggested that something catastrophic happened just before she was transferred back into the hospital. She seemed to

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

Q. We will probably go over that.

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

A. That's correct.

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

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

A. No.

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

A. No.

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

A. I've heard that.

Q. Do you know Dr. Frey?

A. Yes.

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

A. Yes.

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

A. Just acquaintances.
Q. Fair enough.
A. I testified at his VA inquisition.
Q. At Ohio State?
A. No, here, VA.
Q. I thought you said BA. I'm trying to think an inquisition for a BA.
A. No, VA here went after him for some petty reason. I had previously dealt with them on a similar issue so I offered my moral support.
Q. And your testimony I gather?
A. Yes.
Q. Good enough.

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

A. I did not pay attention to that.
Q. Did what the cause of her muscle weakness was have anything to do one way or the other with the issues we're going to talk about? That was a poorly asked question.
A. No, only insofar as it required the use of

very large doses of corticosteroids.
Q. You obviously understood my question, I didn't need to withdraw it.
You don't have an opinion she wasn't required to be on corticosteroid therapy, do you?
A. No.
Q. Is it your intention at the trial which is coming up I think two weeks from today of offering opinions that are supportive of Dr. Sonpal and Dr. Bass?
MR. GOLDWASSER: He hasn't been asked. He knows about Dr. Bass, I don't know about Sonpal.
A. I don't know.
Q. The reason I'm asking, it's not that important, I do like to know ahead of time so we can cover the issues. You said I offer the following comments related to Dr. Steven Bass' involvement, I guess at this point you perceived your role as testifying on behalf of Dr. Steven Bass?
A. That is --
MR. GOLDWASSER: In fairness, he's obviously an ID expert, as relates to that,

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

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

A. No.

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

A. If there is ID questions about the surgery.

Q. Not a problem.

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

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

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

recall writing that?
A. Yes, that is in relation to a statement that preceded that. Specifically in relationship to events at the time the antibiotics were discontinued and then Dr. Bass saw her and the time she was discharged.

The purpose of that statement was merely to state that the fact she was receiving large but decreasing doses of steroids did not impact the things that were or were not done in those final five days in the hospital.
Q. Let's see if we can reach some point of agreement so I hopefully will have an intelligent conversation with you today.

You agree with me because of the dosage and duration of the steroids which she received that she was an immunocompromised patient?
A. She was compromised from the point of view of corticosteroid administration in these doses.
Q. Because the corticosteroids do what to T cell function?
A. They are a lympholytic, they destroy lymphocytes that impact the cell mediated immune system. Response to infection on the part of the host is also antibody mediated, hemoimmunity. Most

importantly of all it relates to the recruitment of white blood cells, the polymorphonucleated leukocytes from the area in the blood where they are marginated and stored, in turn directed toward the area of need where the inflammation is going on.

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

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

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

multiplying.

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

A. Correct.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. In the upper limits of normal is five.

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

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

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

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

Q. In terms of --

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

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

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

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

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

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

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

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

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

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

A. No.

Q. You have no opinion on that issue?

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

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

A. Correct.

Q. Did you in preparation of this report review the hospitalization of 12-23 to 1-5, the one that precedes the perforation?
A. I may have looked superficially, I didn't study it.
Q. You didn't look at it to render your opinion regarding the final hospitalization at Saint Luke's?
A. No.
Q. If you didn't go through it real specifically -- I didn't mean to imply you didn't look at those, I assume you looked at the records?
A. I looked at them with the idea of trying to find out when she was placed on steroid medication. When I looked it was precisely for that particular point only.
Q. Did you happen to know what her baseline white blood count was when it was first taken at Saint Luke's in the confinement of December 23rd through 1-5?
A. I don't recall.
Q. Would you in treating this patient find that information helpful to indicate to you at any given time what a white blood count might mean?
A. No, because you had a different set of

stimuli and circumstances on the subsequent admissions.

Q. Fair enough.

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

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

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

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

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

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

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

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

Q. Let's see. They are always a little above normal, sometimes as high as 103.
A. On steroids?
Q. On steroids.
A. Not 100.3, 103?
Q. 103.
A. Then definitely.
Q. Definitely what?
A. You can have more fever off of steroids than you would have on.
Q. Have you charted the fevers in this patient for the hospitalization at Saint Luke's from 1-9-96 through --
A. I may have looked at the peak temperature, I don't recall charting them.
Q. Do you have an opinion based on an analysis of the record if at any time Mrs. Yarborough was experiencing a fever from antibiotic administration?
A. That's a very difficult diagnosis to make. It's a common event. We have no test for it. As a matter of fact, steroids would interfere with the one test that we do have, which is the appearance of eosinophils in the serum blood because steroids suppress eosinophils.

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

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

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

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

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

A. That is an absolutely correct statement.

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

A. Yes.

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

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

A. Yes.

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

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

Q. And?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

First of all let's start with you

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

A. Yes.

Q. Fluconazole would be effective against Candida albicans?

A. Not all strains.

Q. Generally speaking would it be effective?

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

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

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

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

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

Q. Yes.

A. I would initiate Amphotericin B therapy.

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

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

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

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

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

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

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

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

A. Both.

Q. Explain your answer then.

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

aggressive.

Q. What circumstances would make Candida aggressive?

A. Nobody knows that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Exactly.

Q. Fair enough.

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

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

A. Not specifically those two.

Q. What were you referring to when you wrote that sentence?
A. That 5 to 10 percent of patients either die or have complications following fecal soilage of the intraperitoneal cavity, regardless of their clinical status or variables thereof.
This is a significantly serious disease even under the best of circumstances in terms of getting to the patient quickly, cleaning out the intra-abdominal fecal soilage as promptly and thoroughly as possible. You are going to have problems 5 to 10 percent of the time.
Q. That was the question I want to ask. You weren't limiting this to Enterococcus and Candida, you are saying anyone that has an intra-abdominal catastrophe of this nature, even with an appropriate treatment, coverage for pathogens, there is a small risk that they might die anyway?
A. The signal word that you use is catastrophe. This is as catastrophic as it gets.
Q. That's what I'm trying to determine. It's your contention then a 5 to 10 percent morbidity?
A. Not my contention. That is what the literature shows when you have a perforated colon, you have feces in the intraperitoneal cavity, that

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

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

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

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

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

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

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

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

Q. Fluctuations?

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

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

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

Q. What is a rebound phenomenon?

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

Q. When Carolyn was first admitted to the hospital I believe you'll agree with me, wouldn't have to look it up, she was placed empirically on antibiotics for the contamination in her abdomen, correct?
A. Correct.
Q. I think Gentamycin, Cefotetan and Flagyl?
A. Correct.
Q. Probably a soup, a pretty common I would suspect empiric coverage?
A. I wouldn't use the word common.
Q. They didn't have anything to go on on the day she was admitted what they might be covering for?
A. I disagree with you. When you've got the stool in the peritoneal cavity, you cover for anaerobes with Flagyl; gram negatives with Gentamycin. You need to cover for gram positive, Cefotetan covers for gram positive, also a little bit of a bonus in that you get additional anaerobic done under Cefotetan. It's a combination that cannot be either endorsed or reproached. Not an unreasonable selection of antibiotics. It doesn't cover everything that might be in stool.
Q. I wasn't suggesting that it was unreasonable when I said it was common. What I mean is in the

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

A. I would use the word accepted.

Q. Accepted is fine with me.

A. Not necessarily the best combination.

Q. That is probably a fair assertion also.

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

A. Roughly.

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

A. She was improving.

Q. In what way was she improving?

A. She was alive.

Q. That's good.

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

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

fourth day?

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

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

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

A. Yes.

Q. That is what most doctors do?

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

Q. Absolutely.

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

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

A. Yes.

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

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

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

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

A. I have no idea. No one can have any idea.
Q. Do you have any possible suggestions you are willing to offer?
A. At autopsy there was evidence of the possibility of insufficient blood supply to the intestines. Again that may be cause, may be effect. I have no idea.

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

Q. Can you explain the subdiaphragmatic abscesses of about 10 centimeters found at autopsy that contained Candida fungus?
A. You want me to explain them?
Q. Um-hum.
A. She had soilage of her intraperitoneal cavity some weeks earlier with stool, which normally contains small numbers of yeast and moderate numbers of Enterococci. These are the hardy survivors of her original contamination.
Q. What caused her GI bleed?
A. I have no idea.
Q. Are you sufficiently trained to determine whether the transmural mucosal ischemia seen at

autopsy was a cause or effect of her sepsis?
A. No one can tell you whether it was cause or effect.
Q. Why would you say there is no one?
A. No one can say it caused it or was an effect of the final septic picture she had.
Q. Why can't anyone tell me that?
A. You don't know the time sequence.
Q. Is there some sort of pathological evidence that would tend to support one conclusion greater than the other in your opinion?
A. If she had a chronic vascular insufficiency you might have expected something catastrophic to happen a little earlier.

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

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

If she had dormant organisms

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

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

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

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

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

A. No, I haven't.

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

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

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

A. No.

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

A. There is no way to dispute that.

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

A. There is no question steroids played a role in this case.
Q. I'm going to ask you some general medical questions, give you some statements, see what you agree or disagree with that I say, okay?
A. Okay.
Q. Do you know what fungal translocation is?
A. Fungal translocation is?
Q. Is that a concept you're familiar with?
A. Translocation is a general phenomenon, not limited just to fungal. Bacteria and other organisms in the lumen of the intestine can escape through the wall of the intestine when the integrity of the intestinal wall is compromised.
Q. Specifically are you acquainted with fungal translocation and what certain circumstances in any individual increases that phenomenon?
A. The phenomenon of translocation is a general one in which the integrity, the anatomic integrity of the lumen of the intestine is compromised so the organisms inside the lumen can be transported outside the lumen without there being a gross opening or defect.
Q. In other words it's more or less the passage of fungus into extra-intestinal sites, we will

start with that simple definition?
A. Extra-intestinal sites through the blood stream. Has nothing to do with this case.
Q. Do you agree or disagree immunosuppression of a host increases that opportunity?
A. No.
Q. You do not agree?
A. No.
Q. You obviously agree that physical disruption of the intestinal tract is going to contribute to that phenomenon, that is what you just told me, right?
A. No, I said that -- you asked two separate questions.
Q. Go ahead. So you don't think that disruption of the intestine has anything to do with transport of fungus into areas, other areas in the body?
A. Well now you keep asking it as a nonquestion.

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

they can traverse the intestinal lumen, be extralumenal.

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

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

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

Q. Which part don't you agree with?

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

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

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

We have done this ourselves, in one

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

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

A. I don't recall.

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

MR. GOLDWASSER: What are you reading from?

MISS KOLIS: Reading medical statements.

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

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

THE WITNESS: An article, not the article.

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

A. Right.

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

MR. GOLDWASSER: The author is doctor who?

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

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

In isolation what do you find wrong with that assertion?

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

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

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

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

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

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

MR. GOLDWASSER: Can I see that article?

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

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

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

Q. There is a problem with overgrowth of Candida?

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

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

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

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

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

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

A. Have I ever treated someone?

Q. Yes.

A. Of course I have.

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

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

Fortunately in recent years the

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

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

A. Now you are mixing my response.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Look at the chart if you like to.

MR. GOLDWASSER: Here, the 14th.

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

A. 19,000.
Q. What was it on the 15th?
A. The same, 20,000, that is the same number.
Q. The 16th, was it elevated?
A. 26,000.
Q. Stop right there. Look, you are using the word database, I'm assuming that is a database?
A. On the 17th down to 17,000, the next day it's bouncing around in the same area. This is not a white count to alarm anybody. These are all similar white counts, 20,000, 19,000, 18,000, 17,000, I can't emphasize how many times I've said to you, you are taking a snapshot of a dynamic process. These little changes in numbers don't mean a damn thing. They are totally insignificant.

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

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

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

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

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

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

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

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

A. What is your definition of infected?

Q. What is yours?

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

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

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

Q. Yes.

A. No, she had dormant organisms in there.

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

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

Q. How does the abscess develop?
A. How does the abscess develop?
Q. Um-hum.
A. It developed in a normal fashion after damage, injury and tissue response.
Q. How long does it take an abscess of the size found at autopsy to develop?
A. I have no idea how long it took to develop. I can tell you it wasn't that size, wasn't present on the 25th. I can tell you that with a reasonable degree of certainty. I can tell you somewhere along the line between the 25th and the 30th when she came in and crashed --
Q. Correct.
A. That this organism suddenly woke up from a slumber if it was there at the time, provoked an acute and serious inflammatory response on the part of the host.

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

earlier.

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

A. I have no opinion.

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

A. There is no way of saying that.

MR. GOLDWASSER: We're not claiming that.

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

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(Deposition concluded; signature not waived.)

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ERRATA SHEET

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

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PHILLIP LERNER, M.D.

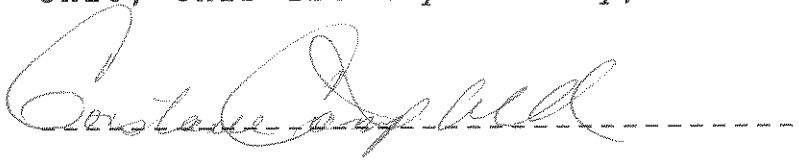
The State of Ohio, :

County of Cuyahoga. : CERTIFICATE:

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

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

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



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

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COVER PAGES = 4

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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**

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MAXIMUM TRACKED OCCURRENCE THRESHOLD: **50**

---

NUMBER OF WORDS SURPASSING OCCURRENCE THRESHOLD: **1**

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LIST OF THRESHOLD WORDS:

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**Candida** [58]

## * * DATES * *

**1-9-96** [2]
*28:16; 31:12*
**1-10-96** [1]
*21:14*
**December, 1995** [1]
*30:5*
**December 3, 1997** [1]
*15:23*
**December 23rd** [1]
*29:19*
**January** [2]
*49:8; 66:17*
**January 14th** [1]
*35:13*
**May 29th** [1]
*16:2*

## * * $ * *

**$300** [1]
*12:2*

## * * 1 * *

**1-10-96** [1]
*21:14*
**1-5** [2]
*29:2, 20*
**1-9-96** [2]
*28:16; 31:12*
**10** [19]
*26:21, 24, 25; 37:17, 20; 39:10; 40:10; 41:21; 44:19, 23; 45:3, 12, 22; 46:12; 47:14; 51:10; 52:13; 53:18; 64:1*
**100** [5]
*37:21, 22; 47:16; 63:5; 64:9*
**100.3** [1]
*31:5*
**103** [3]
*31:2, 5, 6*
**11** [1]
*53:18*
**11,000** [1]
*68:22*
**12** [1]
*53:21*
**12,000** [1]
*68:21*
**12-23** [1]
*29:2*
**13,024** [1]
*68:21*
**14** [1]
*8:17*
**14th** [7]
*35:13; 49:8; 66:17, 23, 24, 25; 67:20*
**15** [3]
*37:17, 20; 64:1*
**15th** [2]
*67:2, 20*
**16th** [2]
*67:4, 19*
**17,000** [2]
*67:8, 12*
**17th** [2]
*67:8, 21*
**18,000** [1]
*67:11*
**18th** [1]
*67:21*
**19,000** [2]
*67:1, 11*
**19,690** [1]
*68:21*
**19,720** [1]
*68:20*
**1995** [1]
*30:5*
**1997** [1]
*15:23*
**19th** [1]
*67:21*

## * * 2 * *

**20,000** [3]
*67:3, 11; 68:19*
**20,360** [1]
*68:20*
**20th** [3]
*41:8; 55:3; 67:21*
**21st** [1]
*67:21*
**22nd** [1]
*68:20*
**23rd** [3]
*29:19; 65:2; 68:21*
**24** [3]
*40:8; 47:10, 11*
**24th** [2]
*68:21; 69:15*
**25** [2]
*9:22, 23*
**25th** [5]
*41:9; 59:9; 68:22; 70:10, 12*
**26,000** [2]
*67:5, 19*
**29th** [1]
*16:2*

## * * 3 * *

**3** [1]
*15:23*
**30th** [1]
*70:12*

## * * 5 * *

**5** [5]
*44:18, 23; 45:3, 12, 22*

## * * 6 * *

**60/40** [3]
*7:2, 5, 7*
**62** [1]
*60:3*

## * * 8 * *

**85** [3]
*63:3, 12, 15*

## * * 9 * *

**97** [1]
*47:12*
**98** [1]
*47:12*
**9th** [1]
*59:9*

## * * A * *

**abdomen** [6]
*32:16; 41:19; 44:11; 48:4; 55:12; 62:21*
**abdominal** [2]
*41:14; 49:1*
**ability** [2]
*23:16; 32:20*
**able** [2]
*13:21, 23*
**abscess** [10]
*51:17; 53:16; 55:12, 20; 69:23; 70:1, 2, 6, 20, 25*
**abscesses** [1]
*52:13*
**absence** [1]
*69:24*
**absolute** [1]
*26:25*
**Absolutely** [4]
*28:9; 50:23; 55:13; 61:12*
**absolutely** [2]
*32:19; 34:12*
**absorbing** [2]
*46:8, 11*
**absorbs** [1]
*46:13*
**Accepted** [1]
*49:5*
**accepted** [2]
*11:16; 49:4*

* * B * *

## * *C* *

## * * D * *

* * E * *

* * F * *

## * * G * *



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* * Q * *



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* * S * *

* * T * *



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* * V * *



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