ORIGINAL

STATE OF ILLINOIS)
) ss:
COUNTY OF COOK)

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT - LAW DIVISION

DOC. 270

KENNETH HANSON,

Plaintiff,

vs.

No. 92 L 07906

RODOLFO PATINO, M.D., ALVARO PENA, M.D., JOSEPH L. GIACCHINO, JR., M.D., RAUL VILLASUSO, M.D., BORYS SUMYK, M.D., MELROSE PARK CLINIC, LTD., an Illinois Corporation, JILL WHITNEY, R.N. SHARON R. STRINGFELLOW, R.N., JENNY PERRY, R.N. LOUISE HOWARD, R.N., and WESTLAKE COMMUNITY HOSPITAL,

Defendants.

The discovery deposition of FRED NELSON LITTOOY M.D., taken in the above-entitled cause, before Lucia R. Filippelli, a notary public within and for the County of Cook and State of Illinois, and a Certified Shorthand Reporter of said state, at 1 North LaSalle Street, Suite 3500, Chicago, Illinois, on the 16th day of May, A.D., 1995, at 8:00 a.m.

APPEARANCES:

LAW OFFICES OF DONALD J. NOLAN, by
MR. PAUL M. MC MAHON,
(One North LaSalle Street, 35th Floor,
Chicago, IL 60602)

On behalf of the Plaintiff;

O'CONNOR, SCHIFF & MYERS, by
MR. GREGORY G. BALOS,
(Two North LaSalle Street, 10th Floor,
Chicago, IL 60602)

On behalf of the Defendant,
Dr. Rodolfo Patino,

LAW OFFICES OF HORVATH & LIEBER, P.C., by
MR. STEPHEN A. WHELAN
(300 West Washington Street, 17th Floor,
Chicago, IL 60606)

On behalf of the Defendant,
Dr. Alvaro Pena and the Melrose Park
Clinic;

THOMAS C. BARATTA JR., & ASSOC., by
MR. SAMUEL A. GARNELLO,
(Midwest Centre, Suite 200,
501 West North Avenue
Melrose Park, IL 60160)

On behalf of the Defendant,
Dr. Joseph L. Giacchino, Jr.

SANCHEZ & DANIELS, by
MS. LORI S. YOKOYAMA,
(333 West Wacker Drive, Suite 500,
Chicago, IL 60606)

On behalf of the Defendant,
Dr. Raul Villasuso,

APPEARANCES: (Continued)

BULLARO, CARTON & STONE, by
MS. AMY L. ANDERSON,
(100 North Riverside Plaza, Suite 2100,
Chicago, IL 60606)

On behalf of the Defendant,
Dr. Borys Sumyk;

CASSIDAY, SCHADE & GLOOR, by
MR. SCOTT J. BROWN,
(333 West Wacker Drive, Suite 1200,
Chicago, IL 60606-1289)

On behalf of the Defendant,
Westlake Community Hospital.

I N D E X

EXHIBITS

MR. MC MAHON: Let the record reflect that this is the discovery deposition of Dr. Fred Littooy, taken pursuant to notice and continued to today's date by agreement of the parties.

(Witness duly sworn.)

FRED NELSON LITTOOY, M.D.

called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. MC MAHON:

Q. Dr. Littooy, could you please state your full name and spell your last name for the record.

A. Yes. Fred Nelson Littooy, L-i-t-t-o-o-y.

Q. Two Ts, Doctor?

A. Yes.

Q. Doctor, have you ever given a deposition before?

A. Yes, I have.

Q. You understand the basic ground rules, that I'm going to be asking you a series of questions, that there is going to be a court reporter who is going to be transcribing those questions and your answers.

First of all, I would caution you to let me finish the question before you answer so that the court

reporter can take down our questions and answers sequentially. Okay, Doctor?

A. Yes.

Q. Secondly, I would just say if there are any questions that you don't understand, I would ask that you let me know that, so that I'll rephrase the question. Otherwise, I'll have to assume that you didn't understand the question, okay, Doctor?

A. Yes.

MR. MC MAHON: Why don't we mark this as Exhibit 1.

(Whereupon Littooy Deposition Exhibit No. 1 was marked for identification.)

BY MR. MC MAHON:

Q. Dr. Littooy, I'm showing you what's been marked Plaintiff's Exhibit 1 for identification.

Do you recognize that document?

A. Yes.

Q. What do you recognize that to be?

A. My curriculum vitae.

Q. Is that CV current?

A. This is 1993, so it's not fully current, but there's probably an additional four or five articles in

addition to what you see there.

Q. Would you be able to recall those articles off the top of your head, Doctor?

A. No.

Q. Are any of those articles articles that would contain issues pertinent to the facts in this case?

A. No.

Q. Doctor, your home address is current on the GV?

A. Yes, it is.

Q. Do you have any intentions to move in the near future?

A. Not in the near future.

Q. Your business address is also correct?

A. Yes.

Q. Do you have any intentions to go into any change of employment in the near future?

A. No.

Q. Doctor, where are you currently employed?

A. Loyola University Medical Center and Hines V.A. Medical Center.

Q. What is your position?

A. Plastic surgery at Loyola and ch ef of the division of peripheral vascular surgery for Hines V.A.

Hospital.

Q. Doctor, if you could give me an idea of what your responsibilities are in regards to your being a professor of surgery at Loyola?

A. My responsibilities are to teach both residents and students to be productive in terms of research, which is primarily my situation, clinical research and patient care.

Q. What about in your role as chief of peripheral vascular surgery?

A. I'm head of that division and responsible for all of the goings-on in the division of peripheral vascular surgery at the Hines V.A. Hospital under the department of surgery.

Q. Doctor, can you give me a breakdown of what your professional week consists of, what types of responsibilities you would take care of on an average week?

A. It's a breakdown between patient care and teaching responsibilities and administrative responsibilities. Patient care is probably about 50 percent of the time; teaching is about another 40 percent; administrative is about 10 percent.

Q. Doctor, do you do any consultation --

obviously you do some consultation on legal cases outside of your other responsibilities.

Can you give me an idea of -- within a percentage, as you just stated, that added up to 100 percent. If you can, include whatever consultations you do on legal cases into your overall job responsibilities. Can you give me a breakdown in that regard?

A. Yes, it's less than 5 percent.

Q. Would be legal consultation?

A. Yes.

Q. Doctor, would that be true in regards to time spent?

A. Yes.

Q. Would that also be true in regards as to a percentage of your income received?

A. Yes.

Q. Doctor, is it your understanding that you are testifying today in regards to your expertise in vascular surgery?

A. Yes.

Q. What makes you qualified to be a vascular surgeon?

A. My training, which involved special training

in vascular surgery beyond the general surgical training and the fact I've been involved in strictly peripheral vascular in an academic setting for the last 17 years.

Q. Could I ask you, Doctor, to go through what we marked in Exhibit 1 as your CV and identify for me the specific items which pertain to your having expertise and being qualified in vascular surgery?

A. On the first page, it's postgraduate training as a fellow in vascular surgery in 1976 to '77, University of California, certification of special qualifications in vascular surgery on the second page by the American Board of Surgery in 1983, for which I've been recertified in 1994.

The fact that I'm chief of the division of peripheral vascular surgery at the Hines V.A. Hospital and the fact that I've been involved in numerous cooperative studies involving peripheral vascular surgery in the V.A. both as principal investigator and as a planning committee member on at least two major cooperative studies. I've been involved in several NIH cooperative studies, clinical cooperative studies, and that my research has been entirely involved in the area of peripheral vascular surgery.

Q. Doctor, I note that you've written many articles. Could you take a quick look at the articles you list in your CV and identify for me which ones you feel have issues pertaining to the matters in this case?

A. Should I just list numbers?

Q. You can give me numbers. That's fine.

A. For the bibliography, the papers that are published No. 4, No. 5, No. 11, No. 22, No. 29, No. 31, No. 41, No. 50. I think that would be it.

Q. Doctor, when you said that would be it, were you just going through the articles?

A. Yes. Do you want to go through the talks?

Q. Please, Doctor, can you go through the books and any presentations?

A. Nothing in the books.

Presentations would start on Page 10. No. 7, 8, 14, 15, 16, 28, 35, 36, 40, 42, 65, 66, 67, 68, 69, 73, 75. That's it.

Q. Doctor, as to your articles, those articles are all published?

A. The articles, yes.

Q. It also says or in press?

A. Well, those are all published.

Q. Do you have those articles available to you?

A. Not readily, but someone -- I mean, they could be looked up in the various journals.

Q. Okay. What about the presentations, Doctor? Do you retain any of those materials?

A. No, I don't.

Q. Doctor, just so that we are clear, the only opinions that you give that are relevant are opinions that are within a reasonable degree of medical and surgical certainty. So when I'm asking you questions, I would ask that you only volunteer opinions that do have that reasonable degree of certainty, and I'll assume that that's the case unless you tell me otherwise, okay, Doctor?

A. Yes.

Q. Doctor, can you go through and tell me what materials you've reviewed in this case?

A. The Westlake materials for admission for a bypass, admission for removal of his toe, admission for epidural abscess and infected leg craft and amputation. And I believe there's some later rehab admissions, too. The office notes of Dr. Villasuso and Dr. Pina, and depositions from the patient and from Dr. Sumyk and one from Dr. Villasuso.

Q. You have a deposition from Dr. Villasuso?

A. Yes, I do.

MS. ANDERSON: Sorry about that.

BY MR. MC MAHON:

Q. Okay. You've reviewed all those materials prior to your deposition today then?

A. Yes, I did.

Q. Doctor, when were you first contacted in this case?

A. Some years ago. I can't remember exactly when. '92, '93 sometime.

Q. Was that by Ms. Anderson?

A. No.

Q. Who were you first contacted by?

A. I believe it was by you.

Q. Ms. Yokoyama?

A. Right.

Q. Would that have been in '92 or '93?

A. Sometime then.

Q. Did you consult with Ms. Yokoyama on this matter?

A. I reviewed something for her and discussed something with her, but I haven't talked to her since then.

Q. Do you have any recollection of the conversation?

A. No, I don't.

Q. Did you make any notes as to those conversations?

A. No.

Q. Were you paid by Ms. Yokoyama for your consultation?

A. Yes, I was.

Q. How much were you paid?

A. I don't remember how much time I spent reviewing the case at that time.

Q. Do you have billing records, Doctor, that would indicate that?

A. I could find that, yes.

Q. When was the next contact you had in regards to this matter?

A. I believe it was from Ms. Anderson.

Q. How long after your consultation with Ms. Yokoyama was that?

A. I don't remember.

Q. Was it within a matter of months?

A. I think so.

Q. Do you know how Ms. Anderson was referred to

you?

A. No, I don't.

Q. Were you retained by Ms. Anderson as an expert at that time?

A. I was asked to review the records and retained as an expert, yes.

Q. What does your retainer agreement consist of?

A. I charge $200 an hour to review the case and $250 an hour for deposition.

Q. Exclusive of the time that you reviewed materials for Ms. Yokoyama, how much time have you spent in regards to this case subsequent to your retainer of Ms. Anderson?

A. Approximately five hours. I'm not absolutely sure about that.

Q. Doctor, was there a reason why you were not retained by Ms. Yokoyama?

A. I have no idea. I discussed it with her, and I never heard back from her, so I don't know.

Q. Doctor, do you recall whether your opinions were favorable or unfavorable to Dr. Villasuso in this matter?

A. They're favorable from my standpoint as I was reading records now, so it must have been favorable

then, too.

Q. Doctor, can I take a quick look at your records?

A. Sure.

Q. Can you tell me, Doctor, have you made any marks in these records?

A. I don't believe so.

Q. Do you use any highlighter or post-it notes or anything like that when you're looking through records?

A. No.

Q. Do you have any notes that you took in regards to these records?

A. Yes, I do.

Q. Is this the sum total of the notes you've taken in regards to this case?

A. That's it.

Q. Do you have any other types of record or memoranda at all in regards to this case?

A. No.

Q. You don't have any types of notes in regards to telephone conversations you made in this case?

A. No.

Q. Doctor, when did you prepare these notes?

A. When I went through the records.

Q. Was that the first time you went through the records for Ms. Yokoyama, or was it the second time you went through them for Ms. Anderson?

A. Probably a combination of the two. I don't remember the timing exactly as to how that came about.

MR. MC MAHON: Why don't you mark these as Exhibit 2.

(Whereupon Littooy Deposition Exhibit No. 2 was marked for identification.)

BY MR. MC MAHON:

Q. Doctor, do you have any other materials contained in your file other than these records and those notes?

A. No. This is correspondence primarily from Ms. Anderson -- I'm sorry. There is one other thing, summary judgment.

Q. Can I take a look at the correspondence, Doctor?

A. Sure.

Q. Doctor, you have a letter contained in your file dated December 9, 1992, from Lori Yokoyama?

A. Yes.

Q. Doctor, would it be fair to say that that is the first contact that you had in regards to that case, somewhere on or around December 1992?

A. I think so. 1 have to look at the timing from Ms. Anderson. I don't remember exactly. It was fairly close I think.

Q. Doctor, you were sent a number of materials from Ms. Yokoyama, is that correct?

A. I believe so, yes.

Q. Did you receive additional materials from Ms. Anderson?

A. Yes, I've gotten depositions from Hanson and Sumyk. And maybe -- I can't remember whether -- and the summary judgment.

Q. You weren't sent doubles of those records?

A. No.

Q. You had some records already, and you received some additional materials?

A. I believe that's correct.

MS. ANDERSON: You may want to look through the correspondence.

THE WITNESS: I will do that and see, because in her correspondence she's listed things she sent to me.

BY MR. MC MAHON:

Q. Why don't you take a look. Is this the only correspondence you received, Doctor? I don't see any letter from him.

A. There's a letter in here, too. This is the deposition date. This is all I have. As far as I know, that's all I have.

Q. That's the only correspondence you're aware of?

A. That's all I'm aware of.

Q. Doctor, there is a letter you had dated April 21, 1993?

A. Yes.

Q. That's from you to Ms. Yokoyama?

A. Yes.

Q. You have a bill for $225?

A. Correct.

Q. Would that have been the sum total of your bill?

A. Yes.

Q. As to Ms. Yokoyama?

A. Yes.

Q. Doctor, in that April 21, 1993, letter it says that the checks are to be made out to Fred Littooy, M.D., Ltd. Are you a limited partnership?

A. Yes.

Q. Are there any other entities that you have? Are you a corporation of any sort?

A. I'm just a sole corporation.

Q. Doctor, as a sole corporation, is that how you received all of your income, from that sole corporation?

A. The income from my practice at Loyola, yes.

Q. What about your consultation on legal matters?

A. Yes.

Q. Doctor, I'm showing you what's previously been marked Exhibit 2 for identification.

Do you recognize those documents?

A. Yes.

Q. What do you recognize those to be?

A. Those are my notes from reviewing the case.

Q. Doctor, they're difficult to read, so I would just ask if you could go through them so that I can understand what they say.

A. Hanson versus Villasuso. 56-Year old, on 6-4-90 presented with a right fifth toe trauma with gangrene. 8-5-90 consulted Villasuso. Glucose was 200 at that time. No history of diabetes. No history of

claudication. Examination of his pulses on the right side show the femoral to be four plus, the popliteal dorsalis petis and posterotibial were absent.

On the left femoral was four plus. The popliteal was described as palpable. The dorsalis petis described as palpable, no posterotibial.

An arteriogram showed a right SFA occlusion at Hunter's Canal. Tibial level disease bilaterally. The right interior tibial was occluded. Questionable posterotibial occluded at the ankle on **8-9-90** at a right femoral above knee popliteal gortex under general anesthesia. Angioscope was used. Debrided the right fifth toe.

8-31-90 right fifth toe, metatarsal phalangeal amputation, which was closed. On Timentin for antibiotic coverage. **11-13-90** decompressive laminectomy. **11-21-90** removal of the infected fem pop graft at, probably, surgery. Graft was occluded. Arteriotomies were closed with Prolene. On **11-28-90** right above-knee amputation.

Then on the next side Villasuso -- those are from his office notes. **8-9-90** fem pop. **8-13** in the office gangrene, fifth toe well-limited.

8-31 amputation. **9-4** office, cellulitis.

Cipro started. 9-11 in the office, improved, staples out. 9-25 abscessed right foot, incision and drainage.

9-27, I believe it is, office, better. 10-2, wound okay. 10-9, debrided. 10-23, debrided. 10-31 much better. Return to clinic in three weeks.

Then notes from Pina Patino. 6-26-90, right fifth toe subungual hematoma, drained it. 8-2-90, right fifth toe tender, painful. Tender and painful again, I guess.

8-4-90 right SFA occlusion diagnosed. Recommend fem pop. 8-24-90 right fifth toe, no cellulitis on Cipro.

10-23-90 lost 20 pounds. Ordered CBC and SMAC, S-M-A-C. Foot healing, secondary to toe amputation. 11-11-90 acute low back pain with lower extremity weakness, admit.

The second card, admitted to Westlake 8-7-90. Fasting blood sugar 171 while on IV. Dextrose will follow. X-ray of the foot, suspicious for osteodistal phalanx. 8-9-90 fasting blood sugar 134 on IVs.

Discharged 8-14-90. On Cipro. Cellulitis of the toe improved. Discharged on a 2,000 calorie ADA diet. Termed a borderline diabetic. No glucose in the urine. Toe amp. Did sign a consent for amputation of

the fifth toe. Done as an outpatient.

Q. Doctor, would it be fair to say that the notes you took are notes that you considered to be important to your forming opinions in this case?

A. Yes.

Q. Doctor, do you have an opinion as to whether Ken Hanson is a diabetic today?

A. Yes.

Q. Doctor, do you have an opinion as to whether Ken Hanson was a diabetic on June 4, 1990?

A. Probably was.

Q. Doctor, what symptoms are indicative of diabetes?

A. They can be polyuria, basically increased glucose in the urine. Some have to go more frequently. They can actually have extra hunger because of it and having to go to the bathroom more often at night. Things like these can be kind of early signs.

There can be other things that can actually come in, hyperglycemic shock. They can sometimes present with infections that you wouldn't expect because they don't heal well, particularly in the lower extremities. There's a lot of ways they can present.

Q. Doctor, what about a problem with distal

pulses, if they were reduced or absent?

A. It can be atherosclerosis. It can be the diabetes. More likely the atherosclerosis.

Q. That's consistent with diabetes?

A. A diabetic has a risk factor for atherosclerosis.

Q. Doctor, do you have an opinion as to the cause of Mr. Hanson's atherosclerosis?

A. Aging, smoking, diabetes.

Q. Would the fact that Mr. Hanson was a smoker have been information that would have been important to you if you were seeing Mr. Hanson on June 4, 1990?

A. Sure.

Q. Doctor, are you familiar with the standard of care for a general surgeon?

A. Yes.

Q. Are you familiar with the standard of care for an internist?

A. Not entirely, no.

Q. Do you have any training in that regard as to an internist?

A. No.

Q. Doctor, would you be qualified to be a general practitioner in medicine?

A. No.

Q. Why is that?

A. I would have to go back and do some refreshing just because I haven't dealt with the broad scope of general practice for 18 years.

Q. Doctor, do you have an opinion as to what the standard of care would have required as to the examination of Ken Hanson on June 4 of 1990?

A. It depends. He had had trauma. As I understand it, he had evidence of a trauma in his toe. There is no evidence at that time that he had diabetes. And I think the examination would have been a local examination looking for any evidence of infection at the area, what the extent of the trauma was, how he was responding to the trauma in terms of healing that, and, perhaps, an examination of his pulses if it was felt to be necessary.

Q. I'm sorry. What was your last --

A. Perhaps an examination of his pulses if he felt it to be necessary.

Q. Doctor, do you know if an examination of Mr. Hanson's pulses were done on June 4, 1990?

A. I do not.

Q. You don't know one way or the other?

A. I don't know.

Q. Doctor, if they weren't done, would that be a deviation from the standard of care?

A. Not necessarily.

Q. Can you explain that answer?

A. Again, it depends on maybe -- if the doctor knew the patient, maybe he knew what the pulse status was. In looking at the foot, there are other things you look at besides pulses to determine whether there was vascularization of the foot, whether this just appeared to be a local problem. He had no previous history that would go along with vascular disease such as claudication.

Q. Doctor, would an initial examination of Ken Hanson on June 4, 1990, require a determination as to whether there's any ischemic changes in Mr. Hanson's feet?

A. Yes,

Q. Are you aware of whether that was done?

A. I don't know.

Q. If that was not done, would you agree with me that that would be a deviation from the standard of care?

A. Well, any time you have an injury to the

foot, you should look for the potential for that injury to heal, which would include the vascularity of the foot.

Q. Doctor, you are familiar with Ken Hanson's medical history, correct?

A. As it's in the medical record, yes.

Q. Is it your understanding that Mr. Hanson was smoking on June 4 of 1990 -- was a smoker?

A. It's my understanding he was, yes.

Q. Would you have made efforts to rule out whether or not Mr. Hanson was a diabetic on June 4, 1990?

A. Not necessarily.

Q. In what circumstances would you have done that?

A. If he had given any history that would go along with it. If he had a family history, if there was some aspect of the healing of this wound that would have, perhaps, alerted me or made me suspicious one way or another.

Q. That's what I'm trying to get at, Doctor. What are those things that would have made you suspicious?

A. It's hard to know. When you see someone with

an injured toe, you don't work them all up for diabetes. That's a long shot. I mean, you have to kind of look at the patient, get the history from them, go along with the injury.

Q. Would you agree with me, Doctor, that Mr. Hanson's age would have been a relevant factor in whether you would be looking for him to be a diabetic?

A. Not necessarily.

Q. Would you agree with me that a person who is in their 50s is more likely to have late onset diabetes?

A. Than who?

Q. Than persons under that age group?

A. Well, because they're earlier and not late, yes, I guess that's true. Diabetes, in terms of adult onset, tends to occur -- it's going to be a higher percentage as patients get older.

Q. Doctor, would you agree with me that the treatment which Mr. Hanson required as a diabetic is different from -- as to his injured toe was different from a person who is not a diabetic?

A. It's a little bit different. You have to be more aggressive with it, yes.

Q. Why?

A. Because of the potential for it to not heal as well and to get secondarily infected.

Q. Doctor, if I were to say that there is a 50 times more likely chance of a diabetic having gangrene as a result of a trauma to a lower extremity than a nondiabetic, would you agree with that?

A. I have no idea where you get 50. It's greater, but I have no idea what the number is.

Q. Can you give me a range of what degree greater in terms of --

A. No, I can't.

Q. You're saying you can't give me an opinion one way or the other?

A. No, because it depends on the amount of vascularity of the foot. If someone has SFA occlusions, they're going to have the same -- potentially develop gangrene that the diabetic does --

(Short interruption.)

THE WITNESS: If they have superficial femoral occlusion or occlusion vascular disease, that's going to be as much of a determinant as their diabetes.

BY MR. MC MAHON:

Q. Doctor, do you teach students at Loyola University in regards to diagnosing occluded arteries?

A. Yes.

Q. Do you teach students at Loyola in regards to femoral popliteal graft operations such as what was done on Mr. Hanson?

A. Yes.

Q. What texts do you use to teach those matters?

A. I use my experience and my own know-it-all for the most part.

Q. Do you use any texts?

A. Not specifically. We recommend texts, but I don't use any specifically.

Q. Are you teaching any students right now?

A. Yes.

Q. What texts are you using?

A. The primary text we recommend is Rutherford's.

Q. I'm sorry? Rutherford's?

A. Yes.

Q. That's the name of the author?

A. Yes, it is. He's the editor.

Q. What is the name of the text?

A. "Vascular Surgery."

Q. Do you consider Rutherford's to be authoritative?

A. As much as any other textbook. It's a -- any book is authoritative just in relation to the people writing it. Everyone has their own opinions. There can be more than one opinion about things.

Q. Doctor, would you expect that a person qualified to do vascular surgery would be familiar with the matters -- with the information contained within Rutherford's?

A. It's a fairly broad question. Someone doing vascular surgery should, yes, because it's a general textbook on vascular surgery. They should have knowledge on that.

Q. Doctor, are there any persons that you could identify for me who are leading authorities on performing femoral popliteal bypass grafts?

A. Numerous people have published on this. Frank Veith is certainly one who has published a lot. John Porter, Floyd Taylor at the same institution, Bob Leather are people who are particularly known for their interest in this area.

Q. What about in regards to treatment of an infected graft? Are there any persons that are leading authorities in the United States in that regard?

A. Not that I could look to, no.

Q. Doctor, could you tell me where these people are located?

A. Frank Veith is at Montefiore in New York. Porter and Taylor at the University of Oregon. Bob Leather is in Albany.

Q. Doctor, would you agree with me that a diabetic such as Ken Hanson would be more prone to have a minor trauma in his foot become infected?

A. Well, he was not known to be a diabetic. He had early onset diabetes at that point, in the very early diagnosis, but even so he would be a little more susceptible, yes, because of his diagnosis, plus in addition his SFA occlusion.

Q. Would make him more susceptible?

A. Yes.

Q. Doctor, would it have been possible for Ken Hanson's occlusion to have been diagnosed on June 4, 1990?

A. Possibly. I mean, I don't know when it occurred. It could have occurred between June 4 and his coming in in August, but more than likely it was present at the time in June.

Q. When you say it was more than likely that it was present at the time, can you explain that?

A. There is no reason that this appeared to be a chronic occlusion when it was on the arteriogram, which was done two weeks later. So more than likely it was present at that point.

Q. What diagnostic methods could have been used to diagnose that occlusion on June 4, 1990?

A. Physical exam.

Q. When you say physical exam, would the matters you discussed earlier with regards to checking distal pulses, taking a history -- were there any other parts of the physical exam --

A. Examining the foot.

Q. As to ischemic changes, those types of things?

A. Yes.

Q. Would you agree with me, Doctor, that determining whether or not there is an occlusion is something that does not require invasive techniques?

A. In general, that's correct.

Q. Doctor, are you aware of whether or not a culture and sensitivity test was done on Mr. Hanson on June 4, 1990?

A. No, I'm not.

Q. Do you have an opinion as to whether or not a

culture and sensitivity test should have been done on Mr. Hanson as to that right fifth toe?

A. As I understand it, he had a subungual hematoma. I don't think that I would necessarily have wanted to do a culture at that time.

Q. Why is that, Doctor?

A. It's a simple trauma. As I understand it, there was no evidence of infection. There is no real reason to do a culture.

Q. It's your understanding that there was no evidence of infection on June 4, 1990?

A. As far as I know. I would have to see exactly what the description of the foot was. My understanding is it was a hematoma under the toenail.

Q. Would it change your opinion at all, Doctor, if there was evidence of infection on June 4, 1990?

A. Well, there has to be something to culture. You can have the cellulitis, but there's nothing to culture with it if there's no drainage -- no culture drainage or an open wound.

Q. Is that a yes then, Doctor? It would change your opinion if, in fact, there was something to culture on June 4, 1990? A culture and sensitivity test is something that would have been appropriate?

A. I would have considered it. Again, you have to look at the patient, look at the situation, but I certainly would have considered it.

Q. Is there any danger to the patient, Doctor, in doing a culture and sensitivity test?

A. No.

Q. Is it an expensive test?

A. I'm not exactly sure what they cost right now. It's probably $100.

Q. Doctor, was it a deviation from the standard of care not to do a culture and sensitivity test on June 4, 1990?

A. If there is no drainage, it was not a deviation.

Q. Doctor, do you have an opinion as to whether at any time in Mr. Hanson's treatment it was a deviation from the standard of care not to perform a culture and sensitivity?

MS. YOKOYAMA: I would object to the form of the question.

THE WITNESS: That's a very long treatment. You have to give me more specifics.

BY MR. MC MAHON:

Q. Doctor, when should Mr. Hanson have been

scheduled for a follow up after June 4, 1990, if at all?

A. Well, I would think within a week or two. I mean, you want to see the results of draining a subungual hematoma and make sure his toe is advancing properly in terms of healing.

Q. Doctor, would you agree it would be a deviation from the standard of care not to follow up within a week or two with Mr. Hanson's presentation on June 4, 1990?

MS. ANDERSON: I want to state an objection. I believe that you've already established that Dr. Littooy is not familiar with the standard of care for a GP or internist.

You can go ahead and answer, obviously, over my objection.

BY MR. MC MAHON:

Q. Can you answer?

A. I know, in general, if you have a problem that you have taken care of that you would like to see the results of it, whether it's by phone, some communication with a patient -- if you're comfortable doing it by phone. But there should have been some sort of follow up, yes.

Q. Doctor, is there any difference between the standard of care required in the treatment of Mr. Hanson between a vascular surgeon and a general practitioner?

A. With regards to his foot?

Q. Correct.

A. No.

Q. Would it be also be true in regards to diagnosing the occlusion in his right leg?

A. A general should be able to diagnosis that, but certainly a vascular surgeon is going to be more attuned to it.

Q. Doctor, what's your understanding as o when Mr. Hanson was first put on antibiotics?

A. I think -- as I remember, I think it was around the 1st of August. I could be wrong about that. But I think it was at the time he was seen, and it was noted that the toe was getting worse. I believe they started Cipro at that time. I think he actually started before that, though. I think he started Cipro before he even came to the hospital, like on the 4th or 5th or something like that.

Q. Sometime in August?

A. Yes. Certainly he was on it in the hospital,

but I think he was actually started before he came into the hospital.

Q. Do you have an opinion as to whether Mr. Hanson required antibiotics prior to August of 1990?

A. I don't believe that he did. In terms of having been seen in June, there was no evidence that he needed it then. When he was seen again in August, I think it was evident that he had an infection of the toe and he needed to be on antibiotics.

Q. Would you agree with me, Doctor, that if follow up had been done on Mr. Hanson, that the infection might have -- or could have picked up sooner?

MR. BALOS: I'm going to object for lack of a time frame.

BY MR. MC MAHON:

Q. Prior to August of 1990.

A. Obviously it developed sometime between June and August. The question is when. Whether it would have been noted on follow up or whether it would have occurred between the last time he had seen him and the next time seeing him in August, I can't tell you that. He might have been seen in the middle of July, and it might have been fine. It might have occurred between

that and when he was going to be seen again. I can't answer.

Q. Would you agree with me, Doctor, that that is why it's necessary to schedule follow-up visits, because of the possibility of infection --

A. Initially, it's to make sure that it's healing correctly, because there was no evidence of infection at that point in time. Certainly infection is something that might occur as part of that follow up. The main thing is follow up with the treatment that you have done, which is drain the subungual hematoma.

Q. Doctor, what is your understanding as to when the first time that Mr. Hanson was noted to have gangrene in the right fifth toe?

A. I believe the first time it was noted was when he was seen in August.

Q. Doctor, if gangrene was noted prior to August of 1990, would that change any of your opinions in regards to when Mr. Hanson needed antibiotics?

A. No, because you have dry gangrene, which does not require antibiotics.

Q. Doctor, do you know prior to August of 1990 whether Mr. Hanson had dry gangrene or wet gangrene?

A. No, I don't.

Q. What's the difference between dry gangrene and wet gangrene, Doctor?

A. Dry gangrene there is no evidence of infection. It's wet gangrene that indicates either some drainage or surrounding cellulitis associated with the gangrene.

Q. Did you note anywhere in the record, Doctor, that Mr. Hanson was noted to have cellulitis?

A. He was noted to have cellulitis on his admission to the hospital.

Q. What date was that?

A. The 5th or 6th, whenever he came in. I can t remember what date that was. I can't remember when he was admitted. I think it was on the 5th. He was actually admitted the 7th, but he was seen, I believe, on the 5th. 8-5.

Q. Doctor, would you agree with me that in light of Mr. Hanson having a gangrenous toe in August of 1990, that that would have been something that a doctor treating him prior to August of 1990 would have been able to note?

A. Gangrene can develop almost overnight in some of these patients. So he might have at least seen some

progression of problems in the toe if he would have been followed up, but I can't tell you that. It can develop very rapidly in these patients.

Q. Is that true for dry gangrene as well as wet gangrene?

A. Well, gangrene goes through stages. You have initial discoloration, it's kind of bluish, cyanotic, then it goes on to gangrene. That change or that staging can take very low amounts of time depending on the situation.

Q. Is it your testimony, Doctor, that that can take place as fast as overnight?

A. Almost as fast as overnight. You go from not hard gangrene, but certainly gangrenous changes on the surface.

Q. I just want to be clear on this point, Doctor. Are you saying that it would be possible for a gangrenous process to develop within a 24-hour period such that a doctor would not be able to identify it if he had not seen that patient within a 24-hour period?

A. The process that is going on to gangrene and nonviability can occur in less than 24 hours. The process of nonviability and gangrene can develop within 24 hours, yes.

Q. Do you have an opinion as to how long Mr. Hanson's gangrenous process took?

A. No, I don't.

Q. You do not see anything in the medical records indicating whether or not Mr. Hanson's gangrenous process had taken long to develop?

A. No, there was very little in the history as to the development of this thing, just that he presented with a bluish-black toe.

Q. Doctor, what is your understanding as to the number of either consultations over the phone or actual visits with the doctor that Mr. Hanson had between June 4 of 1990 and August of 1990?

A. I would have to look at the records again. I can't remember.

Q. Why don't you do that, Doctor?

MR. BALOS: I'm going to object. You're not specifying -- I don't know if you said doctor -- or which doctor you're talking about.

MR. MC MAHON: I didn't.

MR. BALOS: If the doctor can answer the question, he can answer, but I think it's vague.

THE WITNESS: The only records I have are those of Dr. Pina seen on the 26th of June. The next time he

was seen was the 2nd of August. That's all I know about it.

BY MR. MC MAHON:

Q. Doctor, what does the **6-26** note indicate?

A. Pain in the right fifth toe after hitting it, noted a subungual hematoma with tenderness, took an X-ray, drained the hematoma, some sort of dressing. And that's the extent of the notes.

Q. Doctor, what does draining the hematoma -- what would that involve?

A. It depends. If it's under the nail, sometimes they have to actually take like a pin, if you will, and heat it, and pull it right through there so it relieves the pressure.

Q. Doctor, if there was a drainage done on June 26, 1990, would that have been material which could have been used in a culture and sensitivity test?

A. I can't say that it couldn't have been, but there was no evidence that it needed to be done. There was no evidence of infection.

Q. I just asked you if that would be, Doctor, a material that could be used **--**

A. If there was enough of it, it potentially could have been, yes.

Q. Doctor, on the June 26 visit, do you have an opinion as to when it would have been appropriate for Mr. Hanson to have been seen in follow up?

A. Again, if it was just a pure subungual hematoma and he knew the patient or was comfortable with a patient -- as I say, there should have been at least a follow-up phone call. Maybe that's all that would have been necessary. There should have been some sort of follow up within a week I would say.

Q. You're saying within a week?

A. Within a week, yes.

Q. What about in regards to, Doctor, a follow up in which the doctor would be required to visually inspect the toe --

A. As I say --

Q. You have to let me finish the question. As it presented on June 26?

MR. BALOS: Can you repeat the question.

(Record read as requested.)

THE WITNESS: Again, you have to individualize each patient. Potentially, he didn't have to be seen at all. You have to make a decision based on your best judgment after seeing that patient if you need a visual follow up.

BY MR. MC MAHON:

Q. Doctor, you stated earlier that as part of a physical examination it's proper to check for the distal pulses, correct?

A. Yes.

Q. As well as checking for ischemic changes in the foot?

A. Yes.

Q. Doctor, if those distal pulses were done on June 26, 1990, and indicated the same results which were found on August 5 of 1990 at Westlake, in that circumstance, Doctor, what would have been the appropriate follow-up treatment for Mr. Hanson?

A. He should have had a visual follow up under those circumstance.

Q. When should that have occurred?

A. Again, depending on the situation, within a week at least probably.

Q. Why would you need a visual follow up in that circumstance?

A. Because you've had trauma and a potential that it's not going to heal -- or rather it's going to progress in some way.

Q. Doctor, would you have been suspicious of

Mr. Hanson being a diabetic on June 4 of 1990?

A. No.

Q. Why is that?

A. No reason to be. He had no history. He just injured his toe. His trauma wasn't an acute onset out of the blue. If it was something out of the blue, then I would have. But he's actually had trauma to the toe, so I would have figured that's what it was.

Q. Doctor, do you know whether or not Mr. Hanson's family history for diabetes was inquired into?

A. I don't know that. There is no documentation into it, so I can't say.

Q. Would you consider it to be a deviation from the standard of care not to inquire into that in regards to persons such as Mr. Hanson presenting on June 4 of 1990 -- to inquire into that history?

A. I don't think that's a deviation not to ask that, no.

Q. That's true, Doctor, even though you stated that the treatment for a person with diabetes in regards to Mr. Hanson's injury as presented on June 4, 1990, would be different?

A. He had no history, nothing going on to

indicate he had diabetes. He was not a known diabetic. He had trauma to a toe. They looked at it. They thought it was straightforward, relieved with a subungual hematoma. It's fairly straightforward --

Q. Your testimony today is that in regards to a person such as Mr. Hanson presenting on June 4 of 1990 it is not a deviation from the standard of care to fail to rule out whether the person is a diabetic or not?

A. Again, it's an individual thing. I mean, you're looking at trauma to a toe. If it's a localized trauma and seems to be related to the trauma, there is no evidence of infection, you don't necessarily have to go through the whole thing. Even if he has a family history of it, it doesn't necessarily mean that he has diabetes.

Q. Doctor, what is your understanding of when Mr. Hanson was diagnosed as being a diabetic?

A. When he was in the hospital.

Q. Which date?

A. When he was in in August.

Q. Doctor, do you have an opinion as to whether a determination could have been made as to ruling out whether or not Mr. Hanson was a diabetic prior to August of 1990?

A. You could with anybody. You could take anybody in this room and give them a glucose tolerance test. You're not going to go in and have everybody take a glucose tolerance test to rule --

Q. When would you run somebody through a glucose tolerance test?

A. If you suspected they had diabetes, if there was some reason to suspect they had it.

Q. What would make you suspect that, Doctor.

A. I've gone through this many times. If they presented with polyuria, polydypsia, polyphagia. If they had some evidence of other aspect of it such as a urinalysis that showed glucose in their urine, things like that.

Q. Doctor, all those things you're saying, polyuria -- those all require a urinalysis or a blood test, correct?

A. They should, yes.

Q. Doctor, do you have an opinion as to whether a blood test or urinalysis should have been done on Mr. Hanson prior to August of 1990?

A. There is no evidence that this should have been, no.

Q. What's the basis for that opinion, Doctor?

A. I would like to go on that there is no history given of any of the things that I've discussed.

Q. Doctor, would your opinion be different if the history had been given that Mr. Hanson was a smoker who was over 50, who was overweight, who had ischemic changes in his feet, and who had a lack of distal pulses in his right leg or bilaterally? Would that change your opinion?

MS. ANDERSON: I'm going to object. It's an incomplete hypothetical and not accurate to Mr. Hanson's situation. It's not ischemic changes in his toe. It's trauma-induced changes in his toe.

MS. YOKOYAMA: I'll also object. I don't believe there's foundation for the facts that you gave to Mr. Littooy to support your question.

MR. MC MAHON: Could you read the question back to the doctor.

(Record read as requested.)

BY MR. MC MAHON:

Q. Do you understand that question?

A. I understand the question. There is -- none of that's indicated in the documentation when he was seen on the 26th to indicate those things were present.

Q. You're not answering my question, Doctor.

A. If those things were present, as you stated them, it's a total aside and totally different patient, yes, I would do that. I would consider diabetes as something you should look into as part of his situation.

Q. Doctor, under the scenario as we have stated, would it be a deviation from the standard of care not to perform some type of blood testing or urinalysis to rule out diabetes?

MS. YOKOYAMA: Same objection with regard to facts not in evidence.

THE WITNESS: If you have all those things put together, you're going to be evaluating the patient in a different way, and you will be looking at a lot of different factors, which would include fasting blood sugar in the urinalysis.

BY MR. MC MAHON:

Q. I'm sorry, Doctor. I don't mean to press you on this, but, again, you weren't answering my question.

I asked you did you have an opinion as to whether it would be a deviation from the standard of care not to perform the blood testing and urinalysis under the facts that I gave you. You said that you would do it, correct? You would do a blood testing and

urinalysis. What I'm asking is if you were aware of all those things on June 4 of 1990, would it be a deviation not to rule out diabetes?

A. As part of his workup. I don't know whether I would say I think for sure he's got diabetes mellitus or not and just be part of the workup.

Q. I don't understand what you mean, Doctor, by "part of the workup"?

A. Well, I mean, you would be getting these things as -- with a guy like this, you would be doing a lot more work up. You'd be doing an evaluation of things to the point where you might be considering hospitalizing the patient or doing something more aggressive which would include blood testing and urine testing. Obviously considering diabetes is part of the picture.

Q. So, Doctor, you would agree with me that if the information which I gave you was known on June 4, 1990, Mr. Hanson may have needed to have been immediately hospitalized?

A. No, not immediately hospitalized, but he would have had to be monitored more carefully as I've already explained earlier in consideration that this could progress or run a different course than just a

simple drainage of a subungual hematoma.

Q. Doctor, in regards to if that information was known on June 4 of 1990, would that change your opinion in regards to the number and type of follow-up visits required by Mr. Hanson?

A. Yes, it would have.

Q. Can you tell me under those circumstances what type of follow up and number and type of visit would be required?

A. I think I've explained it several times. Within a week, he should have been seen again, and that would have been it. And then you determine at that time if there's any change. Then it would have made a difference as to whether you might want to do something different. If he was making good progress, you would just continue to follow up. If it was turning to something different, then you might have to change your course of treatment.

Q. I don't think we understood each other, Doctor.

You had said before that if the information which I told you before in regards to Mr. Hanson's age, the ischemic changes in his foot -- do you recall that information from my prior question?

A. Yes.

Q. You said if, in fact, you knew that, that the number of frequency and type of follow-up visits required for Mr. Hanson would be different from what you had said earlier about the number of visits.

What I'm trying to do is to quantify, if you can quantify for me, the number of follow-up visits and the type of follow-up visits that would be required under those circumstances?

MR. BALOS: Objection, you're mischaracterizing the Doctor's testimony.

MS. YOKOYAMA: I would also object to the question, because I think you're asking him to speculate with regard to what the condition of the gentleman's foot would have been on each and every visit, which may impact upon his opinion as to how often this patient should be seen. I think the Doctor has just testified that under that scenario he would have at least requested -- or he would have at least had this patient come back for one follow-up visit, which is different from his previous testimony based upon the facts in this case.

MR. BALOS: Or a phone call.

BY MR. MC MAHON:

Q. Doctor, do you need the question read back to you?

A. No, as you've stated it, I said I would see him within a week, and I would make a determination at that time how often he would need to be seen thereafter.

Q. I understand. You're saying you can't give an opinion as to a greater frequency of visits, because you would need to see what would happen after a week?

A. An individual patient, he's got a problem, you have to look it and make a decision based on what you see.

Q. Would you agree with me, Doctor, that under the scenario that I gave you, that there would be a greater likelihood that you would need increased visits and follow up, including a visual inspection?

A. I can't say. I mean, as I say, you have to -- each patient is different. I've seen diabetics with problems like this that heal and others that don't. If he was showing progress in a week, I might have seen him another week later, maybe two weeks later if he was better. If he was showing evidence going in the other direction, I might have seen him the next day or maybe hospitalized him. It just all depends on

what's happened within that week.

Q. Doctor, what's your understanding of the nature of Mr. Hanson's infection in his right fifth toe?

MS. YOKOYAMA: I object. At what point?

MR. MC MAHON: I'll strike the question.

BY MR. MC MAHON:

Q. Doctor, what is your understanding of when Mr. Hanson developed an infection in his right fifth toe?

A. Sometime before August 4.

Q. Are you able to give an opinion, Doctor, as to how long that infection had been there?

A. I have no idea.

Q. Doctor, is it your understanding that Mr. Hanson might or could have had osteomyelitis in the right fifth toe in August of '90?

A. According to the X-ray, there was evidence of potential or a suspicious area for osteomyelitis in the distal phalanx of the fifth toe.

Q. Doctor, is osteomyelitis a serious infection?

A. Depending on where it is it can be.

Q. Do you have an opinion whether Mr. Hanson's osteomyelitis was a serious infection?

A. I would say no.

Q. Why is that?

A. It could be handled so easily with a toe amputation.

Q. As a clinical presentation in how it could be dealt with, you're saying it's not serious.

What I'm getting at, Doctor, is, as a general, untreated infection, is osteomyelitis a serious infection?

MS. ANDERSON: Objection, asked and answered.

THE WITNESS: It depends on where it is. I mean, if it's out in the toe, it's not a serious problem. If it's in the tibia or the fibia or the femur or in the spine, it's a very serious problem.

BY MR. MC MAHON:

Q. Why is that, Doctor?

A. Because of the difficulties in treating it and the difficulties for it being -- the chronocrator of it and the difficulties of -- depending on where it is as to the other things that might be affected by it.

Q. Doctor, do you know how long it would have taken for Mr. Hanson to develop osteomyelitis in his right fifth toe?

MS. YOKOYAMA: I would object to the form of the

question with regard to osteomyelitis. I don't think there's been any evidence whatsoever that on -- I don't remember the date of the X-ray -- I think it was August 8 -- that this gentleman had osteomyelitis.

BY MR. MC MAHON:

Q. Doctor, what's your understanding of whether or not Mr. Hanson had osteomyelitis in the right fifth toe?

MR. BALOS: Asked and answered.

THE WITNESS: The only answer I have is an X-ray was taken. There was an area that was called suspicious. They recommended a bone scan to which there was concern.

BY MR. MC MAHON:

Q. Doctor, assume for a minute for the purpose of my question that Mr. Hanson did have osteomyelitis in his right fifth toe. Doctor if, in fact, that did exist on August 5 of 1990, how long would that osteomyelitis have taken to develop?

A. It depends on how soon the bone was affected by the underlying infection.

Q. How long could that take?

A. It could take a few days.

Q. What would be the long end? Is that the

short end, a few days?

A. I really can't answer your question to be honest. It's some period of time. I can't tell you what it is.

Q. Your understanding of the infectious process would be that there would be a primary infection, and the osteomyelitis would be secondary such that underlying tissue would affect the bone, correct?

A. Not necessarily. Sometimes you can have underlying trauma to the bone which begins the first part of the infection, which then presents itself to the outside.

Q. Doctor, do you have an opinion as to which of those types of osteomyelitis -- assuming Mr. Hanson did have osteomyelitis in August '90 -- he had? Was it from the trauma, or would it have been from --

A. Trauma.

Q. Trauma? So if, in fact, he did have osteomyelitis on August 5, 1990, it would be your opinion it was caused from his initial trauma?

A. Trauma and infection of the toe.

Q. Doctor, how does a trauma to the bone cause osteomyelitis independent of another infection?

A. Well, because you actually have a break in

the bone, you have trauma to the bone, which could get secondarily infected, which could be from an outer cause, be it a puncture wound, which led into the thing. If you have a fracture, you could have it. seeded from another area. So continuing trauma could increase the potential for bacteria to set up in a spot. There's a lot of ways it can occur.

Q. Doctor, would you agree with me that the potential for Mr. Hanson developing osteomyelitis in his right fifth toe was greater due to his diabetes than it would have been if he was nondiabetic?

A. Yes.

Q. Doctor, what's your understanding as to the first indication in the record that Mr. Hanson had an occlusion of any sort?

A. When he was seen in August.

Q. That would be the August 5 visit?

A. I think there was something on August 2 or 4 that was an indication that he had a problem. August 4 for sure.

Q. What's your understanding, Doctor, of how they determined that there was an occlusion?

A. Examining.

Q. Physical exam?

A. Yes.

Q. Doctor, was there anything in Mr. Hanson's physical condition that would have -- strike that question.

Doctor, is it your understanding then that a consult was requested with Dr. Villasuso?

A. Yes.

Q. Do you feel that that was appropriate under the circumstances?

A. Yes.

Q. Why would it be important to consult with Dr. Villasuso under the circumstances?

A. He was a vascular surgeon. They were concerned that the process was going to require an amputation of his toe and whether it would heal because of the occlusion in the artery. So he was asked to see the patient.

Q. It's your understanding, Doctor, that Dr. Villasuso was a qualified vascular surgeon?

A. It's my understanding.

Q. What is your basis for that understanding?

A. Just the fact that he's -- I think that he does vascular surgery in his hospital and that he has privileges to do vascular surgery and considered

qualified to do it.

Q. It's an assumption on your part because he had performed the surgery?

A. Yes.

Q. Are you aware of whether or not Dr. Villasuso is certified as you are to do vascular surgery?

A. Certified in what way?

Q. Where is his certification? I think you have a certification of special qualifications in vascular surgery by the American Board of Surgery?

A. It's not required to do that. It's for surgery, which would be a vascular surgeon, but I don't know whether he has that.

Q. You don't know whether or not he has that?

A. No.

Q. Doctor, what would be required to be qualified to do vascular surgery?

A. He does vascular surgery on a regular basis and has gotten results.

Q. You have to have some initial beginning, though, Doctor, correct?

A. Well, the vascular training programs have only been developed over the last several years. Prior to that general surgeons did vascular surgery as part

of their training and part of their practice.

People who were trained in that way went out and did both types of surgery. Those that did adequate amounts and they had good experience were certainly fully and adequately and competently trained and experienced people to do vascular surgery.

Q. I see your certification in vascular surgery was in 1983?

A. Yes.

Q. Do you know when that certification became available?

A. 1982.

Q. Doctor, are you responsible at all at Loyola University in regards to determining the qualifications of persons for vascular surgery?

A. No.

Q. Have you ever held any position in that regard?

A. No.

Q. When I ask that, I'm asking in regards to along privileges at a hospital. You've never had any function that regard?

A. No. The chief of surgery is the one who allows privileges of the house staff in the chief of

staff's office.

Q. Are you aware, Doctor, whether Loyola requires a certification such as you have in vascular surgery prior to being given a privilege of doing surgery at Loyola?

A. No, I do not.

Q. Would it be fair to say then, Doctor, for the purposes of your opinions, you are assuming that Dr. Villasuso was a qualified vascular surgeon?

A. I'm assuming that, yes.

Q. Doctor, in your notes, which are contained in that Exhibit 2, you indicate a glucose of 200?

A. Yes.

Q. You circled that?

A. Yes.

Q. Why is that important?

A. Just because, as I said, he was diagnosed as having diabetes during this hospitalization. That was just one of the indicators of the increased glucose that was noted during the hospitalization of the diagnosis I would take it.

Q. Doctor, following that you say there is no history of diabetes mellitus and no history of claudication. Doctor, is claudication some type of

blockage in arteries?

A. No. It's a symptom of blockage of the arteries, pain in the leg when you walk.

Q. How would a physician determine whether there was claudication in the arteries?

A. Ask the question, whether a pat ent gets pain in walking.

Q. Okay. So it's also a very simple matter as far as making that determination?

A. Very simple.

Q. Doctor, would that symptom in regards to pain while walking be different in a diabetic than in a nondiabetic?

A. No.

Q. Would you agree with me, Doctor, that a person with diabetes might have less pain in the lower extremities?

A. In what regard?

Q. Doctor, in regards to a person who has diabetes mellitus, is there any literature or anything else within your background which would indicate that a person having diabetes may have a neuropathy which would cause less pain in the lower extremities than a nondiabetic?

MS. ANDERSON: This is all diabetics?

MR. MC MAHON: Sorry?

MS. ANDERSON: This is all diabetics?

MR. MC MAHON: Right.

THE WITNESS: Well, that's two different things. A neuropathy primarily affects the skin level. They can get numbness of the skin, actually loss of sensation in the foot. But in terms of the muscle reaction to pain, it doesn't change that.

BY MR. MC MAHON:

Q. So would it be fair say you would have expected Mr. Hanson to have had a history of claudication prior to August 5, 1990?

A. Not necessarily. An SFA occlusion does not necessarily lead to claudication. They can build up their own blood supply around it and be adequate that they don't get claudication, or they may not walk very far at one time. Maybe he has a very sedentary life and doesn't walk much.

Q. What about the fact that Mr. Hanson has ischemic changes in his foot? Wouldn't that indicate that there wasn't a sufficient collateral blood supply?

A. But still they may not have claudication, because they may not walk that much.

Q. Going back to that initial visit in June of 1990, what prescriptive medicine or measures would you have given Mr. Hanson to go home with?

MS. ANDERSON: I'm going to -- are you asking him for a standard of care opinion, because what he does in his personal practice is different than the standard of care --

MR. MC MAHON: Are you saying what he does in his personal practice is different --

MS. ANDERSON: What a doctor does in his personal practice is not typically standard of care.

BY MR. MC MAHON:

Q. Okay. I'm asking in regards to what you would do, Doctor?

MR. BALOS: Can we have that question --

THE WITNESS: I don't understand the question because --

BY MR. MC MAHON:

Q. Let me ask you another question.

Doctor, you stated earlier that the standard of care would have required Mr. Hanson to have followed up within a week or two weeks subsequent to June 4, correct?

A. Yes. June 26 I believe it is.

Q. Are there any other prescriptions or other advice you would have given Mr. Hanson prior to going home in regards to the treatment of his toe?

A. Just local care of his toe and foot protection. That's about it.

Q. What about elevation of the foot?

A. No particular reason to elevate it, no.

Q. Would you have taken him off of work at that time?

A. It would depend on the type of work he did and the degree of the problem -- the local problem with his toe. I would have to have seen him at the time to make that determination.

Q. Doctor, taking a look at your notes again you indicate tibial level something bilaterally?

A. Tibial level disease bilaterally.

Q. What is the significance of that?

A. It just means that there's occluded vessels at the tibial level, which is more common in diabetics, but it's mainly more just a description of what was seen on the arteriogram, that there was evidence of occlusive disease on those vessels on both sides.

Q. Would you agree with me, Doctor, that given that indication that you would have been more

suspicious that Mr. Hanson was a diabetic at that point?

A. This is when he was in the hospital, and it was determined that he is diabetic.

Q. Doctor, what is your understanding as to when the determination was made that Mr. Hanson was a diabetic?

A. While he was in the hospital in August.

Q. I need you to be more specific than that, Doctor.

A. During his hospitalization in August.

Q. On August 5 of 1990 when he has the glucose level of 200 and the tibial level disease bilaterally, do you believe that was sufficient to make a diagnosis that he was diabetic?

A. Since single fasting blood sugar does not make the diagnosis -- he could have just eaten. He could have had glucose going in his IV. You would have to know whether he was fasting, and you would have to decide whether you're going to do a glucose tolerance test. There are a lot of things that go into it. But the determination was made during his hospitalization that he was diabetic.

Q. I need you to be more specific, Doctor, as to

what understanding of what date that determination was made.

A. 1 don't see what difference it makes if it was made during that hospitalization. I don't think it makes any difference at all.

Q. I'm sorry, Doctor, I ask the questions --

A. I have no idea. Probably the 5th, 6th, one of those days. I don't know. Sometime when he was in the hospital.

Q. The reason I ask that, Doctor, is because you stated there are reasons to believe that he wasn't a diabetic, correct, that he could have had problems with his IV and glucose and things of that nature, is that correct?

A. It's possible, yes.

Q. What basis do you have then to believe that the diagnosis was made that he was diabetic on that day?

A. He was put on an ADA diet. The notes in the hospital said that they considered him to be a mild adult onset diabetic, so I have to go on what the doctors say.

Q. That was in early August prior to the bypass?

A. It was during that hospitalization. I would

have to look at the note and look at the date.

Q. I would like you to do that, Doctor.

A. On 8-9 I noted that his blood sugars were remaining elevated every time they were done, so I think they were probably fairly suspicious at that point. So I would say probably on the 9th would be the first time they were making that determination as far as I can tell.

Q. Doctor, you indicated earlier that you would have been suspicious of diabetes on August 5 of '90 with that elevated glucose level and with the tibial level disease bilaterally, correct?

A. I can't tell you about the glucose levels. I don't know when that was drawn, but certainly with the pattern of disease and the arteriogram I would have been suspicious, yes.

Q. Doctor, do you have an opinion as to whether or not Mr. Hanson needed to have measures performed that would rule out whether or not he was a diabetic prior to the bypass?

A. No.

Q. What's the basis for that opinion?

A. The treatment is the same. They put him on a sliding scale in terms of treatment of the glucose. It

all has to do with how you control the glucose. They knew it was elevated, so they were watching that. It's a very simple procedure.

Q. Is it also true in light of the fact that there was an indication in the record that he was suspicious for osteomyelitis at that point. Would that fact make it any different as to when diabetes needed to be ruled on?

A. No. You're going to treat the osteomyelitis the same.

Q. How do you treat osteomyelitis, Doctor?

A. It depends on where it is and what the situation is. If it's a bone in the mid foot and you're trying to save the foot, you may put him on a six-week course of IV antibiotics and see if you can get it to heal. If it's out on a digit, you're more likely just to take the toe off, because it's a simple procedure and they don't need the toe.

It kind of depends on where he is and what the situation is for the particular patient and the potential to heal it with IV antibiotics or not. If not, then it usually has to be surgically debrided and removed in addition to being on antibiotics.

Q. What type of antibiotic, Doctor? Would you

have any idea?

A. Generally, you would like to have a specific for the particular bacteria that's in the osteomyelitis. If it's somewhere that you can't get to it, then you take your best guess as to what's growing in it and put him on an antibiotic that you think will cover it.

Q. What type of infection did Mr. Hanson have on his right fifth toe when he presented on August 5, 1990?

A. What kind? I can't tell you. I don't know what was growing from it.

Q. That's because there wasn't any determination made as to what bug it was, correct?

A. As far as I know, there were no cultures taken of that toe.

Q. Doctor, was that a deviation from the standard of care, not taking a culture and sensitivity to determine what bug was in Mr. Hanson's right fifth toe at the time?

A. Well, the problem is all they had was a surface scuff. You don't know what that is. That could be a conglomeration of a whole bunch of things. When it comes off the surface, it might not have been a

problem culture. So they used a broad spectrum antibiotic which is very appropriate in a diabetic or someone they considered to be diabetic.

Q. Doctor, is it your opinion that there was no way for a culture and sensitivity test to be done on the right fifth toe prior to the surgery, the bypass surgery?

A. I can't tell you that exactly. All I know is that there were gangrenous changes with some cellulitis. I don't know whether there was actually drainage or any stuff that could actually be cultured.

Q. Does the fact that there was cellulitis there indicate there was live tissue that could be cultured?

A. Not necessarily, no.

Q. If, in fact, Doctor, there was some material that could be cultured, would it be a deviation from the standard of care not to culture that in determining what that bug was prior to the bypass?

A. If there is was a definite discharge that appeared to be infective or that you could easily culture and that you felt was a true indicator of what was going on in the wound, I would say you should culture it, yes.

Q. Doctor, one of the reasons for that is

because there are methicillin resistant bacteria in which only special types of antibiotics will properly treat those, correct?

A. In general that's true, but someone off the street very rarely has that infection. It's usually a hospital-acquired infection.

Q. What is the proper treatment, Doctor, for a methicillin-resistant infection?

A. Vancomycin.

Q. Doctor, do you have an opinion as to whether Mr. Hanson required Vancomycin on August 5 of 1990?

A. I don't have an opinion on that, no.

Q. Is that because you don't have enough information?

A. I don't have any culture to indicate that he needed to be on that.

Q. Doctor, it's your understanding they started Mr. Hanson on Cipro in early August of '90?

A. Correct.

Q. Do you think that that was an appropriate antibiotic?

A. Yes.

Q. Why is that? What is Cipro supposed to treat?

A. It's a broad spectrum. It's gram positive, gram negative, which you can see in mixed infections in his foot -- in foot problems.

Q. Do you know what dosage Cipro they put Mr. Hanson on on August 5 of 1990?

A. I can't remember. I think it was 500 milligrams every six hours.

Q. Doctor, do you know what the maximum dosage allowable is under the PDR for Cipro?

A. I don't know off the top of my head, no.

Q. Can you give me your best understanding of what a maximum dosage for Cipro would be?

A. I can't off the top --

Q. Would it be more than 500?

A. At the most I'm sure it would be a gram, probably 500 to 1 gram, but I'm not sure.

Q. Doctor, generally speaking, would you agree with me that an increased dosage of Cipro would be able to deal better with an increased degree of infection? Just generally speaking.

A. Well, that all depends. Your dosage depends on the severity of the infection to some degree, and this is isolated to the toe. And at this point in time, I think a regular dose would have been

sufficient -- considered sufficient.

Q. When you say a regular dose, would 500 milligrams be a regular dose?

A. I would think so, yes. I would have to look that up.

Q. Doctor, what is your understanding as to why Cipro was prescribed?

A. For the exact reason I said about three minutes ago. It's a broad-spectrum antibiotic, which they felt that they wanted to use, because apparently they didn't have anything to culture.

Q. I guess I'm getting at the more basic part of that, Doctor. Is it your understanding that Cipro would not be prescribed unless there was evidence of infection?

A. Absolutely. I mean -- well, that's not necessarily true. If there was some reason that they felt they wanted to be prophylactic, but I think they did it because they felt it was an infection, because there was cellulitis evidence at the toe base.

Q. The fact that there was cellulitis was indicating that there was an active infection that needed to be treated?

A. Yes.

Q. It's your understanding that it wasn't to be given as a prophylaxis, that it was being given to treat the evidence of infection at the toe?

A. That's correct.

Q. It's your opinion that Cipro and the dosage given was appropriate under those circumstances?

A. I believe it was, yes.

Q. Doctor, what would the standard of care require in regards to the follow up as to whether the Cipro was working or not?

A. Check the evidence of the cellulitis in the toe and see if it's improving.

Q. How often would you do that?

A. If the patient is in the hospital, you're going to see him on a daily basis.

Q. What if the patient was discharged?

A. Well, then you would have to determine at that time the severity of the infection and the severity of the problems and the local management of it on how often you have to see them. And that would depend, again, on the individual situation. It could be on a daily basis. It could be twice a week. It could be once a week.

Q. Doctor, you mentioned a couple of times that

amputating the right fifth toe is a fairly simple solution. That's a vague question. I'll strike that.

Doctor, would it be fair to say that if Mr. Hanson had presented to you on August 5, 1990, with his history and problems that are identified -- symptomatology that are identified on August 5, that you would have taken off the toe at that time?

A. No.

Q. When would you have taken off the toe?

A. After he had been revascularized.

Q. How soon after he was revascularized would you have taken off the toe?

A. It would depend on the situation. If you thought you could clear the infection, it would be best to do that first, because then you could move your amputation out more distally.

If the infection doesn't clear, you have to do what's called an open amputation and allow the wound to secondarily heal, which could take a prolonged period of time.

If you are trying to do a primary operation, which you remove the toe and close, you would like to see the infection cleared first. Again, you have to individualize this and look at the individual patient

and decide which course to take.

Q. Doctor, are you telling me you don't have enough information before you as to whether you would have done something different than what was done here?

MS. YOKOYAMA: I would show a continuing objection to all these questions. You're asking the doctor what he would have done, and I don't believe that's an appropriate standard with regard to an expert in a medical malpractice case. I think the proper form of the question is what did the standard of care require, not what this doctor individual doctor would have done.

BY MR. MC MAHON:

Q. Can you answer the question, Doctor?

A. As I see the question -- of course, I have the whole course laid out in front of me. I know that it improved with antibiotics, and it was totally appropriate. If you tried antibiotics and things weren't improving, then you would have had to do an amputation earlier.

Q. It's your understanding, Doctor, from what you see in the records that Mr. Hanson's infection improved?

A. Yes.

Q. Where do you see that, Doctor?

A. It's stated, I think, just before his discharge that cellulitis was improving.

Q. You have a note on your page 2 that says, "Discharge 8-14-90 with Cipro, cellulitis, said toe improved"?

A. Yes.

Q. Doctor, discharging Ken Hanson on 8-14 of '90, when would the standard of care require that Mr. Hanson be seen for follow up?

A. He should have been seen within a week.

Q. Would it be a deviation from the standard of care not to see Mr. Hanson under those circumstances within a week?

A. Yes, I think he should be seen within a week to 10 days, something like that. He should be seen in a fairly quick fashion after. He's got an incision on his leg. He's got a toe that has improving cellulitis that you have to be sure is continuing to improve. You have to make decisions about when to take his toe off, depending on how that progresses. You have to see the patient to make those decisions.

Q. Doctor, the osteomyelitis that Mr. Hanson had in his right toe, was that a stable condition, or was it potentially progressive?

MS. ANDERSON: I'm going to object. That's a misleading question, because it's already been discussed in his deposition that osteomyelitis was never formally diagnosed. It was a suspicion on the X-ray.

BY MR. MC MAHON:

Q. Doctor, I want you to assume for the purpose of my question that osteomyelitis was present. Can you answer the question assuming that?

A. If you want to assume that it was, it appeared he had a stable condition -- or improving actually.

Q. What physical indications, Doctor, would there be that an osteomyelitis is improving?

A. Cellulitis improving.

Q. That would also indicate the osteomyelitis was improving, if it was there?

A. It means it's stable. You don't know if the osteomyelitis is improving or just staying stable, but the reaction to it in the surrounding tissue is improving.

Q. Doctor, assuming that there was osteomyelitis there, would that change the amount of time you would have wanted to see Mr. Hanson for follow up, or would

you not have discharged him from Westlake?

A. The course they chose to take, I would have discharged him, yes. I would not have changed the number of times that I saw him.

Q. You would still want to see him within a week, 10 days?

A. Yes.

Q. Doctor, are there any diagnostic methods to determine whether or not osteomyelitis exists -- is present?

A. There's X-rays that you can take that look at cortical destruction. You can do nuclear medicine scans. The problem is you have other inflammation going on in that, too, so it would be localized there so you couldn't tell if it was in the bones or whether it was just in the tissues.

You can actually do an open biopsy, which you certainly wouldn't do on his toe. He was going to take it all off, so you wouldn't do a biopsy on it unless you were going to try to save it and give him long-term antibiotics, but that wasn't a concern. It's just a localized problem at the tip of toe. And the bigger problem is not the osteomyelitis, but just the infection that can occur at the interface between the

gangrenous changes in the toe and the rest of the foot.

Q. Can you explain that for me, Doctor? Why would that be important?

A. Well, because that's going to determine -- if the infection spreads from the toe onto the forefoot, then you may change the toe amputation to a forefoot amputation. And if that spreads, you change that into a full-knee amputation, et cetera, et cetera.

Q. Doctor, would you agree with me that it would be important to determine the extent of osteomyelitis in order to determine where the amputation might be needed?

A. Well, they have determined that already by the X-rays --

Q. Answer my question, Doctor. You're going back to what they did. I asked you a question.

Why don't you read the question back for the doctor.

(Record read as requested.)

THE WITNESS: Well, they did an X-ray. That's the only extent that you're looking at.

BY MR. MC MAHON:

Q. I'm not asking what you did, Doctor. I added specifically --

A. You're asking me how to figure it out, and I said you take an X-ray. They took it.

Q. Doctor, you're saying that the X-ray would be sufficient to determine the extent of the osteomyelitis for that purpose in making a decision as to an amputation or not?

A. Yes.

Q. It's your understanding that the X-ray was done in this case?

A. Yes.

Q. It's your understanding that the X-rays showed cortical destruction?

A. It showed some cortical -- I can't remember how it was written.

Q. Why don't you take a look at that, Doctor.

MS. ANDERSON: Can we take a short break?

(Short recess.)

THE WITNESS: The report indicated the examination shows some destruction of the cortex of the distal phalanx of the fifth digit, highly suspicious for osteomyelitis. No other fractures identified, bony cortices are otherwise intact.

BY MR. MC MAHON:

Q. Doctor, is there enough information for you

on that report to rule out osteomyelitis, whether or not there is?

A. To rule it out?

Q. Yes.

A. There is nothing there to rule it out.

Q. Is there enough information there for you to make the diagnosis that osteomyelitis existed based on that?

A. I would say I'm suspicious, just like they are. They're not coming out saying it for sure. They're the ones that read these. I would have to go along with their approach to it.

Q. Is there any diagnostic methods, Doctor, that could make a more certain determination than that X-ray?

A. Well, as I mentioned, it's a triple-phase bone scan which is a problem here because of all the other inflammation and it being such an isolated little area. And there is an open biopsy that we've talked about before. And the other would be a follow-up X-ray and see if there is further destruction of the bone.

Q. Is it your understanding that any of those measures were done in this case?

A. I don't believe they were.

Q. Do you have an opinion as to whether there was a deviation from the standard of care not to do any of those --

A. I do not believe it's a deviation, no.

Q. When you say it's not a deviation in the standard of care, Doctor, is that true as well in regards to whether or not Ken Hanson's toe needed to be amputated or not in early August of 1990?

A. I don't think it was a deviation from the standard of care that his toe amputation was delayed, no.

Q. Assume for the purpose of my question, Doctor, a follow-up procedure had indicated a spreading osteomyelitis. Would that change your opinion with regard to whether or not Mr. Hanson needed an amputation of the right fifth toe in early August of 1990?

MS. YOKOYAMA: I would object to the question. I believe it's totally speculative. There are no facts in evidence which would possibly support, first of all, that there was an absolute osteomyelitis present during his hospitalization or that it was spreading at any time during his hospitalization.

BY MR. MC MAHON:

Q. Do you understand the question, Doctor?

A. Yes, I do. I didn't see any evidence that there was such spreading, because it would be shown by the evidence in the rest of the foot. Even if it did further destruct the distal phalanx, it doesn't make any difference in the treatment of the patient. What matters is its affect on the foot.

Q. Let me make my question clearer.

Doctor, if a further diagnostic procedure than was done here indicated -- I'm just asking you to assume for the purpose of my question that there was some further diagnostic procedure that showed an osteomyelitis that was spreading into the foot, would that change your opinion at all in regards to whether or not Mr. Hanson required an amputation in early August of 1990?

A. Well, this study was done on the fifth?

Q. Correct.

A. Osteomyelitis doesn't spread like that. It's a slow process. It has to work into the bone. It takes, at the least, several days to see much in the way of changes. Sometimes you have to wait two weeks to see what you may think clinically is an osteomyelitis to see the changes on an X-ray. It's a

slower process. The actual evidence of any spreading in the foot would be shown by what you see in the soft tissues in the skin.

Q. Doctor, if osteomyelitis was present on August 5 of 1990, would you agree with me then that was an infection that had been there for some period of time?

A. It could have been there for some period of time, yes. Did it just happen overnight, no.

Q. Can you give an opinion within a reasonable degree of medical certainty as to longest amount of time that it would have been there?

A. I can't tell you that. Certainly several days.

Q. Doctor, was there a clinical reason not to do an amputation of the right fifth toe prior to the bypass?

A. The problem with doing it prior to the bypass is you're working through an inflamed area. You're going to do actually an open amputation. You're going to get necrotic skin or changes which then may -- even with the revascularization -- require a more proximal amputation, either of the metatarsal or -- which then gives him a more unbalanced foot and more potential

problems, particularly being a diabetic. You would get an unbalanced foot, that you get pressure points elsewhere, which can lead to later problems. So you like to minimize the extent of the amputation as much as possible. If you keep it out to involve only the phalanx, you're in pretty good shape. That's what I would look at it and what Dr. Villasuso was attempting to do.

Q. I'm not sure if you're agreeing with me or not, then, Doctor. It sounds like we are in agreement that it may have been a good thing for Mr. Hanson to have his toe amputated?

A. No, I'm not saying that, because he had cellulitis at the time. He would have had an open wound which would have required a more proximal amputation than he ended up finally having, and it could have led to a bigger problem in his foot because the period of time between the amputation and the time you revascularize, you're going to get necrotic -- changes of the skin edges, and you're going to end up having to take it further back.

Q. Doctor, when Mr. Hanson presents on August 5 of 1990, was it a forgone conclusion that he was going to lose his right fifth toe?

A. Yes.

Q. Why was that?

A. It was gangrenous. It was going to autoamputate or it was going to have to be amputated primarily surgically.

Q. Autoamputate means it was going to fall off?

A. It was going to fall off.

Q. Doctor, in regards to the matters that you stated would be problematic, in particular this amputation prior to the bypass, which of those potential complications would not have existed at the end of August when the amputation was done?

A. Well, as I read the notes from Dr. Pina and Dr. Villasuso, the infection cleared, and it was only left with a distal gangrenous toe, which then allowed the amputation in a relatively clean field at the MP joint.

Q. Metatarsal phalangeal joint?

A. Yes.

Q. Doctor, what's your understanding as to how the determination was made that the infection had resolved prior to the amputation?

A. As I understand it, by looking at the evidence for cellulitis and the skin changes that were

occurring at the time of the hospitalization which were starting to improve and continuing to improve on follow up.

Q. Doctor, would the standard of care have required any follow-up X-ray or other diagnostic procedures in regards to osteomyelitis prior to the amputation on August 31 of 1990?

A. I don't think so.

Q. Doctor, might or could a further diagnostic procedure have shown that the osteomyelitis had spread?

A. It could.

Q. But it's your testimony, as you sit here today, that the standard of care did not require ruling out that possibility?

A. No, because you're going to be -- number one, it's remained limited to the toe. There has been no evidence that it's spread, so it's there. You know where it is.

Q. There is no evidence because they didn't check, right, Doctor?

A. It's a limited process to the little toe. If it has spread even to the next phalanx, it makes no difference.

Q. How do you know whether it's spreading or

not, Doctor, without doing a diagnostic procedure?

A. You don't, but it doesn't make any difference clinically.

Q. Please explain for me what you mean by that. It doesn't make any difference clinically?

A. Because you're going to take this all off. The spread would only be within this toe. It's going out. It's gone. It doesn't matter.

Q. I see. What you're saying is that he's going to have to have his toe off either way, there is no need to determine whether osteomyelitis spread on the toe?

A. That's correct.

Q. Because he's going to get the toe chopped off?

A. That's correct.

Q. Doctor, if, in fact, the osteomyelitis spread to the foot, he might or could need an amputation of portions of his foot, correct?

A. If you see evidence of osteomyelitis in the foot, you would see other changes, soft tissue changes. There was none of that.

Q. Doctor, is it possible for osteomyelitis to be present without those soft tissue changes?

MS. YOKOYAMA: I would object to the form of the question as to what is possible. I don't believe that's the appropriate standard.

THE WITNESS: In this situation I would say, no.

BY MR. MC MAHON:

Q. I didn't ask you in this situation.

A. Any osteomyelitis will show soft tissue changes at some point.

Q. Your testimony today is that -- you're answering, no, that it isn't possible for osteomyelitis to be present without some soft tissue change, correct?

A. Eventually you would see some, yes.

Q. You keep changing your answer on me, Doctor.

A. I'm not changing. I said eventually you would see something. There's always going to be some soft tissue change, otherwise you're not even going to know it's there. That's the reason that it presents, because it has to present on the surface for you to know if there's something wrong.

Q. You also know that it's there because you saw it in the X-ray, correct, Doctor?

MS. ANDERSON: I would object. There has been no definitive diagnosis of osteomyelitis prior to that.

MS. YOKOYAMA: I would join in that objection.

THE WITNESS: All we know is there is a suspicion of osteomyelitis in the distal phalanx. It's in the toe. It comes up. It's gone.

BY MR. MC MAHON:

Q. Your opinion within a reasonable degree of medical and surgical certainty is that it's within the standard of care for a vascular surgeon, general surgeon, or other doctor not to rule out whether or not the osteomyelitis had spread beyond the toe, correct, Doctor?

A. I don't think it's -- within the standard of care I would not have repeated the X-rays prior to removing the toe.

Q. You didn't answer my question.

A. I do not think it was a deviation from the standard of care not to get a further X-ray of the foot.

Q. You're not answering my question, Doctor, because you keep -- why don't you read him back my question. It's a yes or no question.

A. It's yes or no -- in answering your question --

Q. You can qualify it.

A. I'm trying to.

Q. But I want to have an answer to the question first.

A. I'm trying to qualify it.

(Record read as requested.)

MS. ANDERSON: I want to state an objection. You're mischaracterizing his testimony. He's indicated to you that you can rule out the existence of osteomyelitis by looking at clinical changes in the tissue of the foot.

BY MR. MC MAHON:

Q. Did you understand the question, Doctor?

A. Well, the problem is that question doesn't totally relate to the situation. I mean, osteomyelitis is here, is located in the area of the injury, and the area of the local infection. It doesn't just spread all over the body and doesn't just spread up -- march up the bones. So I would not -- I would say, yes, they do not have to have another X-ray to rule out anything in the foot.

Q. Doctor, is it your testimony that there is no risk of spreading osteomyelitis from the toe to the foot and up the bone?

A. That's correct. Cellulitis can occur. Spreading infection can occur in the soft tissue, but

the osteomyelitis is not going to ascend up the foot.

Q. How would an infection spread from an original osteomyelitis in a right fifth toe?

A. Just as I've talked about. It ascends up through the soft tissues, through the tendon sheaths, through the fascia. There's all sorts of ways that it spreads, which are all soft tissue approaches and soft tissue spreads that have nothing to do with ascending up the bone.

Q. Would you agree with me, Doctor, that it could as well become blood-borne or spread through the lymph glands?

A. It could, yes.

Q. Doctor, would you expect osteomyelitis to spread to the foot from the right fifth toe prior to it spreading to other areas of the body, or is it the converse of that?

A. When you saw the osteomyelitis spread, you mean the infective process that goes to the soft issues?

Q. You're right. Let me correct that question.

Doctor, as to the infectious process in Mr. Hanson's right fifth toe, would you expect that to be seen in the foot if it spread prior to it being seen

in other parts of the body?

A. I would expect that, yes.

Q. Why would you expect that?

A. Because the patient is on antibiotics which should control it, keep it localized. So I would expect if things got out of control, you would see a local problem first.

Q. Is that because, Doctor, the nature of an infectious process is that it's going to be more difficult for the antibiotic to fight that infection at the localized area in the other parts of the body?

A. I don't quite understand that question. You give the antibiotics to fight it locally, and you gave new blood supply down there to allow the antibiotic to get down to this area better. So you have a combination now of increased vascularity and the ability to get the antibiotic even better to the source and to localize the process there.

Q. I need you to explain for me, then, why you testified that you would expect to see it in the foot prior to the other parts of the body. Why would that be?

A. If you don't control it, you're going to se -- because you lose local control first, and then it

could spread into the lymphatics. It can spread into the blood. But to keep it localized out to the toe, the potential of that is extremely small, almost infinitesimal. For it to spread more, it's going to have to have a bigger -- in other words, evidence of loss of control of it locally.

Q. Doctor, would amputating Mr. Hanson's right fifth toe as he presented on August 5 of '90 have prevented the spread of the infection in the right fifth toe?

MS. ANDERSON: Could you read back the question, please?

(Record read as requested.)

MS. ANDERSON: There is no factual support for that question that the infection in the right fifth toe ever spread. Are you asking him if the toe should have been amputated on August 5? I'm not sure.

BY MR. MC MAHON:

Q. Do you understand my question, Doctor?

A. Not exactly. I'll ask you a question. You mean spread in the toe -- if you take it off, it couldn't spread in the toe.

Q. You're right. Spread from the toe. I apologize. With the change in the question, Doctor,

spreading from the toe.

A. Without vascularity you have the potential that any bacteria in the interface would still have a problem. That's why you like to get a revascularization at or before taking the toe off as long as you don't have an infection that's out of control. If you have infection out of control, you do an amputation first. He did not present with an infection out of control.

Q. Doctor, could Mr. Hanson's right fifth toe have been amputated, culture taken of the soft tissues at the site of the amputation, and a culture done of those tissues to determine what the bug was that was down there?

A. It could have been, yes.

Q. Do you know whether or not one was done in this case?

A. I do not know that. I don't believe it was.

MS. ANDERSON: We're two and a half hours into the deposition, and I'm still waiting for questions about the standard of care for Dr. Sumyk at this point, which is what this expert is here on behalf of as related to the motion for summary judgment.

MR. MC MAHON: I would make a statement for the

record that I spoke with counsel prior to this deposition, and she indicated -- and you can say if it's not correct -- that her position would be that she would not be presenting Dr. Littooy for a further deposition unless his opinions change, a position that I disagree with, but that is the basis for me going more into depth with Dr. Littooy's opinions.

BY MR. MC MAHON:

Q. Doctor, do you have an opinion in light of Mr. Hanson's clinical findings as they presented the day of the graft prior to the bypass graft being done as to whether or not an autogenous or prosthetic craft should have been used?

A. Either was fine.

Q. Would you agree with me, Doctor, that there is a greater risk of infection in the use of a prosthetic graft?

A. There is a slight increase, yes, very small.

Q. Do you know what the percentages are for that, Doctor?

A. Percentages of graft infections are 1 percent or less.

Q. I guess what I'm getting at, Doctor, is what the difference would be in the greater risk in using a

prosthetic graft versus autogenous graft?

A. It's never been studied, so there is no answer to that.

Q. It's your understanding, Doctor, that there isn't any literature out there on that?

A. That's correct. There's never been a randomized trial to look at that question.

Q. Doctor, do you have an opinion as to whether or not Mr. Hanson's risk of an infection in the graft was increased or decreased as a result of the use of a prosthetic graft as opposed to an autogenous graft?

A. I don't have an opinion that it was increased, no. I do not think it was increased. I do not think that the risk was increased.

Q. Doctor, is there any difference in the standard of care in regards to whether a graft is to be done above or below the knee?

A. That's totally dependent on the anatomical presence of the occlusion and whether you can get around the occlusion by staying above the knee or whether you have to go below the knee to bypass the occlusion. It's totally based on where the occlusion is.

Q. What's your understanding of where

Mr. Hanson's occlusion was?

A. It was at the Hunter's Canal, which is the area in the distal thigh above the knee. And he had a reconstitution of a normal popliteal artery below that, but which was still above the knee, so they were able to get a bypass above the knee.

Q. Doctor, did Mr. Hanson have a saphenous vein available for an autogenous graft?

A. He had not had it removed for anything else, but whether it was adequate is another question. I don't know that it was looked at.

Q. You don't know one way or the other?

A. No, I don't.

Q. Doctor, is there any difference in cost to the patient as to whether or not an autogenous or a prosthetic graft is used?

A. The difference is the cost of the graft. The charge for the operation is the same.

Q. Tell me what that difference is, Doctor, cost of the graft?

A. The grafts in this situation are probably about $750 to $800.

Q. You're talking about a prosthetic graft?

A. Yes.

Q. How long, Doctor, would a fem pop bypass normally take?

A. How long does it take to do?

Q. Correct.

A. That will vary on the surgeon, but it could take anywhere from an hour to three hours. This particular type of operation, femoral above the knee with prosthetics, should be done in about two hours on average.

Q. Would the time it would take, Doctor, be different if you were going to use an autogenous vein as opposed to a prosthetic graft?

A. It takes longer.

Q. How much?

A. It depends, but maybe add an hour to the procedure.

Q. You said earlier that the cost of the surgery would be the same?

A. In terms of the cost of the surgeon, the anesthetic cost would go up because they charge per hour, so there would be an increased cost from the anesthetic standpoint.

Q. What about as to the vascular surgeon?

A. No.

Q. His cost would stay the same whether you used autogenous vein or graft?

A. There may be a slight increase in the use of autogenous vein. I think some surgeons charge a little more for the use of the autogenous vein.

Q. Do you charge any more for that, Doctor?

A. We do this all through the business office. I can't tell you for sure. I think we charge a little more.

Q. Okay. Would the little more that you're saying compensate you for the extra hour of time?

A. Yes. I mean, that's why it is. It's a little more difficult procedure.

Q. Doctor, would an operation involving an autogenous transplant with that extra amount that you're charging for the time, how would that compare to a prosthetic graft transplantation with that lesser time. I guess what I'm getting at it, does the longer amount of time make it more overall expensive for the patient, or does the greater expense of the graft make it overall more expensive?

MS. **YOKOYAMA:** I would object to the question. You're not really going to try to imply that a decision to use a gortex graft was based upon the amount of

money Dr. Villasuso was going to make performing a gortex procedure versus using -- or doing an autogenous graft.

BY MR. MC MAHON:

Q. Do you understand my question, Doctor?

A. It's probably a wash. I don't know.

Q. That's what I wanted to get at. Is that a wash?

A. Probably.

Q. Doctor, you're here today to testify in regards to what the standard of care is as to a first assistant surgeon?

A. Yes.

Q. In this case you're also here -- you were retained by counsel for Dr. Sumyk?

A. Yes.

Q. Do you agree with me that you are qualified to give an opinion in regards to what the standard of care was for Borys Sumyk in regards to his role with Ken Hanson?

A. Yes.

Q. Doctor, what is the general standard of care in regards to the responsibility and duties to the patient that a first assistant surgeon would owe to a

patient such as Mr. Hanson having the bypass procedure that he did?

A. Well, their obligations and responsibilities here have to do with assisting the primary surgeon to make the operation easier; to make it go well, efficiently; and that will, thereby, improve the patient care, the patient situation, in a given operation.

Operations cannot be done by a single person. They require assistance to expose and to help with the doing of the anastomosis in this case. And the more experienced and qualified that assistant is, the better that is for you.

In this situation Dr. Sumyk was the general surgeon and, I think, a board certified general surgeon. And many surgeons out in the community practice -- because they don't have the residents like you're dealing in an academic center -- would depend upon the use of assistants. And they try to get the best assistants they can, which are usually general surgeons who aren't busy or attending internists who are taking care of the patient to help them in surgery.

Q. Doctor, what is your understanding of Dr. Sumyk's qualifications to have been the first

assistant surgeon in regard to that bypass procedure?

A. I would say his qualifications are excellent.

Q. What I'm asking is what is your understanding of those qualifications?

A. Well, that he's a practicing general surgeon and, thereby, has gone through a training program at which time he's obviously first assisted in many cases. He's been out in practice. Because he's gone through a training program, he understands operations, the conduct thereof, and understands how to assist another surgeon. And from that standpoint I would see him as a very competent person to help Dr. Villasuso.

Q. Do you know Dr. Sumyk?

A. No.

Q. Have you ever worked with him in any regard?

A. No.

Q. Do you know any of the physicians in this case?

A. No.

Q. Are you familiar with any of the physicians in this case professionally?

A. No.

Q. What about socially?

A. No.

Q. Doctor, were you provided with a CV of Dr. Sumyk?

A. I can't remember whether I was or not. In his deposition it was gone through what his background was, and that's where I got it.

Q. So the basis of your opinions in regards to Dr. Sumyk's qualifications are based upon that deposition?

A. In large part, yes.

Q. What other matters other than that deposition would you be basing that on, if you don't know him and you haven't seen a CV?

A. Through a CV, and talking to Ms. Anderson, the fact that he's done a lot of first assisting.

Q. So you were provided with his CV?

A. I didn't mean CV, I'm sorry. I meant his deposition.

Q. Is your understanding, Doctor, that Dr. Sumyk is a board certified general surgeon?

A. I have to read through it again. I can't remember whether he's board certified or not.

Q. Doctor, what qualifications and training would be required of Dr. Sumyk prior to him being allowed to be a first assistant to do a bypass

procedure such as he did? I'm sorry. I want you to go all the way back to education.

A. Well, he's -- I mean, I could backtrack a lot. I mean, a first assistant could be anywhere from a physician's assistant to a surgical tech to an MD of some sort. Whether it's the interns taking care of the patient, whether it's a surgeon, first assistants can have a whole gamut of experience. It just depends.

In his particular situation, this is a man who has gone through medical school. He's gone through a surgical training program. He's out practicing general surgery. So this would put him in a higher group, as I would look it at, of people who have the ability to assist another surgeon.

Q. Doctor, is it your testimony, then, that a person less than an MD would have been qualified to act as the first assistant to Dr. Villasuso in regard to this bypass procedure on Mr. Hanson?

A. They could be.

Q. Do you recall, Doctor, seeing in Dr. Sumyk's deposition that there was a policy at Westlake in regards to the necessity of the first assistant being an MD?

A. No, I don't remember that.

Q. Based on what you're saying, you wouldn't be aware of any need to have such --

A. I --

Q. Let me finish the question. Sou wouldn't be aware of any need to have such a qualification, correct?

A. Not to my knowledge, no.

Q. For that type of procedure as it was done on Mr. Hanson in August of 1990, the bypass, have you ever used persons with lesser qualifications than an MD to be a first assistant?

A. I have not, no.

Q. How many of these procedures have you performed, Doctor?

A. Fem pop bypasses? Probably 500 or so.

Q. Are you the go-to guy at Loyola, Doctor, for a fem pop bypass, or are there other doctors?

A. There are three of us.

Q. What are their names?

A. William Baker, Howard Greisler, G-r-e-i-s-l-e-r, and myself.

Q. Doctor, what would be the standard of care required of an MD, a general surgeon, such as Dr. Sumyk, in regards to a review of Mr. Hanson's

medical chart prior to surgery?

A. I don't think the standard of care would require that he review it at all necessarily.

Q. In what circumstances would the standard of care not be required?

A. I don't think the standard of care does require that he review the chart.

Q. You said "necessarily" and you're qualifying that. Are you changing your necessarily?

A. I'm changing my necessarily, yes.

Q. So, Doctor, when you are performing a fem pop bypass, would it be your expectation that your first assistant surgeon would have no knowledge of the patient's history or clinical condition?

A. I'm sorry. What was my expectation? What did you say?

MR. MC MAHON: Why don't you read it back to him.

(Record read as requested.)

THE WITNESS: My expectation would not be that, because I'm in a trained hospital with residents and expect them to be learning from this.

In a community hospital, it could be a totally different situation where you're looking for good qualified help, and that's what you're most

concerned with.

BY MR. MC MAHON:

Q. You're saying, Doctor, that there is a difference between the standard of care in regards to what -- strike that. Because you're not saying that. You're saying what your expectation would be.

A. Yes.

Q. Is there, Doctor, a difference between the standard of care at a facility such as **Loyola** or Westlake Community Hospital in regards to the standard of care of the first assistant surgeon in a fem pop bypass?

A. No, I don't think so.

(Short interruption.)

(Short recess.)

BY MR. MC MAHON:

Q. Doctor, what is the need for a first assistant surgeon for a fem pop bypass specifically? Can you get into the specific types of things that the person is going to do?

A. Sure. Initially is the dissection of the vessels which requires two people to retract, because to encircle the vessels and dissect them out properly without entering the vessels or other things in the

area is a two-person type of thing.

Secondarily, when you do the bypass itself, to do the suture line requires a second and a first assistant to both follow the suture and expose the graft edge and the arterial edge to allow you to have accurate placement of the sutures.

Q. Is there anything else?

A. That's primarily it.

Q. So, Doctor, would it be fair to say that there is no requirement similar to an aircraft where there is a pilot and a copilot in case the pilot has the heart attack that the first assistant be able to take over and close the person up?

A. That's not the requirement, no.

Q. Is there any understanding that you're aware of in that regard that that's one of the reasons why you might want to have an MD there?

A. No.

Q. Would it be true, Doctor, that there would be no need to have a first assistant surgeon who would be qualified to perform a femoral bypass secondarily to the vascular surgeon performing it?

A. Correct.

Q. Doctor, what would be the standard practice

in regards to informing the first assistant surgeon about the procedure that is going to take place?

A. Just tell them what you're doing basically. I think basically they're going to come in and help no matter what it is, but just a general knowledge of what kind of case you're going to be working on.

Q. The primary vascular surgeon doing that grafting type of procedure, is it important for that doctor to brief specifically in regards to what this person's physical condition is?

A. I would not say that that's necessary, no.

Q. What are the types of things that are important for that first assistant to know about the patient's clinical condition?

A. Not much really. I mean, the surgeon is the primary caretaker of the patient along with, perhaps, an internist. And the assistant is not involved in the primary care of the patient. He's involved in assisting the surgeon in the operation.

Q. You keep qualifying your answers. You said "not much." Are there any things, Doctor, that the primary vascular surgeon would want the first assistant surgeon to know prior to assisting in a fem pop bypass such as Mr. Hanson's?

A. In a fem pop bypass, I would say no.

Q. You would be comfortable going into an operation with a first assistant surgeon having no knowledge of the patient's history or clinical condition on a fem pop bypass such as Mr. Hanson's?

A. Yes, I would.

Q. Doctor, what is your understanding in regards to Borys Sumyk's relationship to Ken Hanson?

A. I'm sorry. His relationship to Ken Hanson?

Q. His relationship to Ken Hanson.

A. As far as I know, he didn't know who he was until he walked into the operating room.

Q. Did Dr. Sumyk have a doctor-patient relationship with Dr. Hanson for that surgery?

A. No. Not that I'm aware of, no. I'm only qualifying that if you mean preoperatively and interoperatively I would say, no. I do believe he saw the patient postoperatively when he was covering -- Dr. Villasuso was either off for the weekend or out of town or something.

Q. Doctor, it's your understanding that a doctor-patient relationship wasn't established with Mr. Hanson as to Dr. Sumyk until the postoperative visits?

A. That's my understanding, yes.

Q. There would be a doctor-patient relationship established at that time?

A. A minimal one only as someone covering for Dr. Villasuso.

Q. What is your understanding in regards to how Dr. Sumyk came to be at that surgery for the bypass procedure?

A. My understanding is an hour, hour and a half before the procedure he was called by Dr. Villasuso and asked him to assist him in this case, because someone who was going to assist him was unable to.

Q. So as to Dr. Sumyk, is it your understanding that that was a doctor provided by Westlake Hospital?

A. The doctor that was going to help him?

Q. No, Dr. Sumyk?

A. Oh, that he was provided by the hospital?

Q. Correct.

A. No, I think he has a relationship with Villasuso and that he has first assisted him on several occasions.

Q. That's a doctor that's being provided by Dr. Villasuso?

A. Yes. That would be my understanding.

Q. What about the other medical -- let me ask you a preliminary question.

What medical persons would be necessary to do the procedure that was done Mr. Hanson on August 9?

A. What medical persons?

Q. Correct.

A. You need the primary surgeon, Dr. Villasuso.

Q. Right.

A. And the other medical people would be the anesthesiologist. Aside from that it's, as I say, the first assistant, who is an MD in this particular case. It doesn't have to be an MD. So the two primary physicians would be the anesthesiologist and the primary surgeon.

Q. Do you need any other medical personnel assisting in any capacity?

MS. ANDERSON: Meaning nurses?

THE WITNESS: Other medical personnel sure. There is scrub nurse. There is a circulating nurse, maybe some CRNAs that are working with the anesthesiologists. I don't know how it works in that hospital. He used an angioscope. There may have been someone who helped set up the angioscope. Other than that, I think that would be it.

BY MR. MC MAHON:

Q. Doctor, is it your understanding that the medical personnel other than Dr. Villasuso and Dr. Sumyk were provided by Westlake Hospital?

MR. BROWN: Objection. The doctor just testified he didn't know how it worked at this hospital.

THE WITNESS: I don't know how it works. I don't know if it's contracted out or the hospital provides --

BY MR. MC MAHON:

Q. I asked you what your understanding was for the purpose --

MR. BROWN: Objection. He just said he doesn't have an understanding of what the hospital does.

THE WITNESS: I don't know how the hospital works.

BY MR. MC MAHON:

Q. Doctor, 1 asked you for the purposes of your opinions in this case what your understanding was as to where those medical personnel were provided for that operation?

MR. BROWN: For the third time, I'm going to object. The doctor testified that he does not know how Westlake Community Hospital operated its operating room procedures and has no basis for any such testimony.

MS. ANDERSON: He's not indicated where those

people came from has any basis to the opinions.

THE WITNESS: I don't know. I would just assume they were provided by the hospital, but I would have no idea.

BY MR. MC MAHON:

Q. Doctor, the persons who you described would be necessary to perform that fem pop bypass, was that the minimum number of people that would be necessary?

A. Yes, I would say the minimum. You have to have an anesthesiologist, a primary surgeon, a scrub nurse, and a circulating nurse.

Q. Do you know whether or not that was provided in Mr. Hanson's case?

A. I think it was. I would have to look at the -- there is a procedure that indicates who those particular people are.

Q. I'll move on. Doctor, do you have an opinion as to whether or not -- first of all, Doctor, is it your understanding that Mr. Hanson had his right fifth toe debrided on the fifth -- I'm sorry, during the operation on the 9th?

A. Yes.

Q. What would be the purpose of that?

A. Maybe there was some necrotic tissue at the

base of the gangrenous area. I don't know. It wasn't well-described. It just said there was a debridement.

Q. You don't know one way or the other what the purpose of that debridement was?

A. No, I don't.

Q. Doctor, could a debridement aggravate an infection such as what was in Mr. Hanson's right fifth toe?

A. Theoretically it should enhance it, because if there is necrotic tissue or material that you removed, it should take away the dead tissue, which will have a greater propensity to have infected material in it, make it harder for the new blood supply to clear the area, just a matter of trying to make the wound easier to clear, if you will, the infection and whatever was going on.

Q. Doctor, would there ever be a circumstance where a debridement of the right fifth toe as it was in Mr. Hanson's case on August 9 would contraindicate a debridement of that toe?

A. I don't understand the question. I mean, if there's tissue that's devitalized, it would make sense to remove it. On the surface that's what you're concerned with, because what you're trying to do is

to -- in his situation was to try to move his amputation out. So he was trying to do everything he can to keep it limited to the toe, and that would be my understanding of what he was doing. It should not make things worse.

Q. Doctor, is your opinion different at all if, in fact, there was osteomyelitis in that toe on August 9, 1990?

A. No.

Q. Doctor, did you note in the records anything in records to the purpose for not amputating the toe on the 9th?

A. As I described, he wanted to revascularize the area and look for a demarcation, which would be as far as out as possible. And he felt that he could do that by revascularizing and minimize the amount of amputation you would have to do and do a primary amputation at the time he did it rather than leave it open.

Q. Doctor, I believe you testified it's within the standard of care to do what he did in that regard?

A. Yes.

Q. Doctor, if Mr. Hanson's toe had been amputated either on August 9 or within a few days

thereafter, would that have had any affect on his future condition?

A. I don't understand that question. I don't understand -- you would have had to have had an open amputation, so you would have had to had an open wound that would have secondarily healed, which could have taken weeks to months to happen. And I guess that's the only thing different that I can see.

Q. If he had had an amputation that day, the wound might have taken a number of months to heal?

A. It depends on the situation. With the revascularization you would hope it would be within four to six weeks to heal, but sometimes in diabetics it can take a long time.

Q. Doctor, what risks would Mr. Hanson have in relation to that length of time it would take for that toe to heal?

A. Well, you have an open wound and you have an area for actual infection to go in. And given some potential of infecting the bone at the distal end or you cut it off, hopefully your revascularization is going to allow enough blood supply so that it will heal and won't have any problems with it. An open wound is more difficult to deal with for the patient as far as

dressing changes, et cetera, et cetera.

Q. Doctor, could you characterize the risks and weigh the risks involved in amputating the toe on August 9, 1990, as opposed to the risk of the antibiotic which Mr. Hanson was being given not working?

A. I don't think there's any real difference in the risk, because you're going to be watching the patient. If you see the antibiotics aren't working, you just go ahead and take the toe off. If you see that they are working, you continue the course that you've decided upon, which is to see if you can clear the infection and do a more distal amputation, which you could close primarily.

Q. Doctor, would you agree with me that the treatment of a patient such as Mr. Hanson would have required a doctor to make an analysis as to what was the best method to save as much of his lower extremity as possible?

A. Yes, that's what it was all about. Yes.

Q. Would you also agree with me, Doctor, that amputating below the knee as opposed to above the knee would be beneficial to Mr. Hanson?

A. Absolutely.

Q. Why is that?

A. Because it's a much more efficient energy-saving amputation in terms of the rehabilitation, their ability to get around, much less work required if your knee joint is left intact. If fact, you can usually return almost to the same 1 vel of ambulation or one level less with a below-the-knee amputation, much better than above the knee. Usually it's more much restricted.

Q. What functional problems, Doctor, would a person have who has his right fifth toe amputated?

A. Zero.

Q. Doctor on August 5, 1990, was it a forgone conclusion that Mr. Hanson was going to require an above-the-knee amputation?

A. Oh, no.

Q. Do you have an opinion, Doctor, as to whether at the time of Mr. Hanson's amputation above the knee that there was any potential to save the leg?

A. As I read through those notes, I would say -- well, to be quite honest, it's not well-characterized what's going on with his leg when he comes in at the time of his back problem. The first characterization I see of his leg is almost prior to his amputation, at

which time there were severe progressive problems distally. It was cool clear up to the knee. I don't think there was much option but to do an above-the-knee amputation at that point in time.

In terms of revascularization and revascularizing his leg when they took out the occluded graft, it wasn't even clear when that graft occluded, whether it was occluded when he came in or whether it occluded after he got into the hospital. There's no description of what's going on in his leg until two or three days after his back operation, so I can't tell you.

And then it depends on the degree of the infection, because then you would have had to do some sort of a bypass with a long segment of vein where I would have had to come in above the inguinal ligament and brought a graft somewhere laterally down to some vessel lower in the leg. And it would have been -- the chances of that working would not have been great under the circumstances.

A lot depends on what the viability of the leg was at that time. It wasn't clear to me in reading this chart how severe things really were.

Q. Doctor, do you believe that it was within the

standard of care not to attempt to save the leg?

A. Yes.

Q. Was is the reason for that?

A. If he had a severe infection, number one, you've got an infection at the groin level, you've got an infection throughout out the length of the graft, as I understood it, an infection in the back. You have a lot of things going on with this guy at the same time, which would have made a long procedure to try to save this leg very risky. I'm not even sure the leg was salvageable. The way it was described at the pathology, it sounded like it was a necrotic foot, gangrenous foot, and not even salvageable.

Q. Doctor, do you have information -- you keep saying it's not well-described.

Do you have enough information to make that determination?

A. Not really because, as I say, it's very vague as to what's going on with this leg throughout.

There was an indication that there was a discussion with the patient about the possibility of doing some sort of extra anatomic repair versus amputation, and the doctor and patient came to the conclusion to do the amputation.

Q. Doctor, you're referring to a conversation between the doctor and the patient.

Do you recall what the risks inherent in making attempts to save the leg -- how those were described to Mr. Hanson?

A. No, I do not.

Q. There's going to be risks in any surgical procedure, correct, Doctor?

A. Yes.

Q. Would you agree that an attempt to do another bypass, a graft bypass, might or could have saved Mr. Hanson's leg for at least some period of time?

A. I can't make that judgment, because 1 don't know what the leg was like.

Q. Doctor, are you aware of any medical literature in regards to using an autogenous vein after a prior graft bypass has become infected as a method to attempt to save a leg such as Mr. Hanson's?

A. Absolutely.

Q. There's medical literature that would support that, correct?

A. It can be done, but you have to individualize the situation, what it would have required to do that. You don't put it back in the same bed, you have to find

clear areas to come from and to go down to. In him that would have been -- had some real problems.

Q. Doctor, was the only method to revascularize Mr. Hanson's lower extremity -- right lower extremity by means of a graft bypass?

A. Yes -- at what point in time?

Q. I mean prior to the bypass being done.

A. You mean August?

Q. Correct.

A. Again, I have not seen the angiograms. They described a relatively short occlusion of the SFA. There's some potential, although this was 1990, and I don't know the situation at Westlake, but some people would try to open that up with a balloon. But the long-term outcome of that is extremely poor with an occluded vessel, particularly down this far on the leg. And most people would do a bypass for that particular problem.

Q. Were there any other procedures in 1990 other than doing a balloon and an angioplasty?

A. For bypass, no. Those were the two procedures that were --

Q. What is an endarterectomy?

A. An endarterectomy is basically where you just

isolate the area that's blocked. You open it up, clean it out, attach it, or just close it back up. But that has been basically dropped from favor for many, many years now. It's one of the original operations done for this type of conclusion. It did not have good long-term success, so it's been given up.

Q. Doctor, would you agree with me that the fact as you stated that this was a relatively short occlusion would make that occlusion more favorable to a balloon procedure than a longer occlusion?

A. Well, any occlusion does not work as well as a stenosis, that is, if you just have a narrowing; but when you actually have the artery blocked off, then the results are much worse. The further down the system you go, the results get worse and worse. If you dilate arteries up high, you have fairly good results. As you move down, the results are much worse.

Here you would not have necessarily been able to get a balloon across it. If you have an obstruction, you have to be able to get a wire across the obstruction first, then you either dilate it or you put in lytic drugs to try to get rid of any clot there is and see if there is an underlying shorter lesion which could then be dilated. There's a lot of things

you go through with that. But nevertheless when you have a total occlusion, the results are certainly less than 50 percent in six months of being opened.

Q. I'm sorry. You would expect that only to last for up to six months?

A. At least.

Q. How long, Doctor, would you expect a prosthetic graft to be viable?

A. In his above knee, the fact that you could use an above knee, he should have about a 60 percent, four years.

Q. What if you use an autogenous?

A. It would be a little better, probably around 70, 75 percent.

Q. How many years?

A. Four years.

Q. Doctor, do you have any patients that have had better results than that?

A. One patient -- when we're talking about percentage here, one patient --

Q. Who have gone beyond your four years?

A. Yes. That's an average. That's 60 percent do. That 60 percent that do can go on for long periods of time. I've seen patients go as long as 10 years

with bypasses.

Q. Is there a long end that no bypass is going to be viable?

A. No.

Q. It could go on as long as the person's entire life?

A. Yes.

Q. Doctor, is there any literature in regards to a preference for the use of autogenous veins in a fem pop bypass such as Mr. Hanson's?

A. If you have to cross the knee, you would prefer to use an autogenous vein.

Q. Did they have to cross the knee in Mr. Hanson's case?

A. No. And those percentages I gave you are for above-the-knee bypasses, not across-the-knee bypasses.

Q. Which are the ones that apply to Mr. Hanson?

A. Right.

Q. I believe you testified earlier that there is no preference for an autogenous or a prosthetic vein above the knee, correct, Doctor?

A. That's correct.

Q. But you did also testify that a prosthetic graft is more susceptible to infection?

A. Somewhat, yes. It's a very small difference.

Q. And that autogenous vein would also have a greater likelihood of success over the long-term?

A. Over the long terms it works a little better. It's not statistically different, but it is a little better, yes.

Q. Doctor, could you describe for me what indications would exist in a patient in which -- in light of those favorable circumstances for an autogenous graft that a prosthetic graft would still be used?

A. Several things. Here is a man who has tibial level disease, a potential for progression for that disease, a potential for the need for further operations. So many people because of this and because of the relatively favorable long-term results from above-knee prosthetic grafts would prefer to use the prosthetic grafts; save the vein if it's needed for a later distal bypass, at which time it would have to be used then, and some potential -- because these patients have atherosclerosis that they may need a heart bypass at some point in the future, too.

Q. Doctor, would you agree with me that the potential for a heart bypass would not be the

overriding concern in a situation such as Mr. Hanson's case where you're trying to save the leg?

A. That's correct.

Q. Doctor, did you note in the records any indication as to the graft infection?

A. Yes.

Q. Do you recall what type of infection was in the graft?

A. As I looked through the chart, I did not see any culture results. I did not know what it was.

Q. Does that matter to your opinions at all, what those culture results were, if they were done?

A. It would be interesting to know what they are, yes.

Q. Doctor, do you recall ever seeing any culture tests done on the infectious process of the spine?

A. I never saw any results. I know that it was wrote out in his discharge summary that it was staphaureus, which was Methicillin and Gentamicin resistant, but I never saw the actual result in the chart.

Q. Doctor, do you have an opinion as to the cause of the staphaureus in Mr. Hanson's spine?

A. It was probably blood-borne. He did not have

a spinal or epidural anesthetic in his first operation, so that would not have been a source to introduce something into the area. As far as I know, he didn't have any back injuries although -- my guess is it was blood-borne.

Q. Doctor, you said you read Dr. Villasuso's dep?

A. Yes, I have.

Q. Do you recall seeing in his dep that he stated that the cause of the infection in his spine originated from the infection in the toe?

MS. YOKOYAMA: I would just object to your characterization of that statement. I don't think that's a proper statement made by Dr. Villasuso during the course of his deposition.

MR. MC MAHON: I asked him what he recalled, and he said that was correct.

BY MR. MC MAHON:

Q. Doctor, is your answer still correct?

A. I just read through it briefly this morning, but it seemed like he was linking things together.

Q. Do you have an opinion, Doctor, as to whether Dr. Villasuso's opinion is correct?

A. I don't know that, because I don't know what

the original infection was in the toe. I don't even know what grew out of the graft.

Q. Would you defer to Dr. Villasuso's opinion in that regard in light of him being the treating physician in this case?

A. In general I would say, yes. He's on the front lines. He's evaluating the patient and making an evaluation based on what he sees.

It looks like he drew something different from the graft versus what he drew from the back. He drew pseudomonas from the yraft and staphaureus from the epidural abscess. There were two different bugs.

Q. Does that change your opinions in this case?

A. Well, again, we never have any cultures from the toe, so I don't really know what was down there. As I say, it could be a mixed infection. He was on antibiotics for a long time. He could have had staphaureus down there, too. He could have had pseudonomas down there. Pseudonoma is an unusual primary infection, but it does occur.

Certainly the graft infection does not appear to be the source of the epidural, because they're two different bugs.

Q. Doctor, I want you to assume for the purpose

of my question that there was a Methicillin-resistant infection in the toe and that it is connected to -- causally connected to the later Methicillin-resistant infections noted in the spine, okay?

Assuming those facts, do you have an opinion as to whether Vancomycin being given to Mr. Hanson in August of 1990 might or could have prevented the spinal infection?

A. Number one, he may not have been given Vancomycin if they drew staphaureus out of the toe, because they took the toe off. That's basically taking away the source of infection, and you don't need to treat that once you've taken that away. So it's not an easy answer.

Q. Separate and apart from that type of treatment of taking it off, might or could the Vancomycin have prevented the infection in the spine in that scenario?

A. It depends on whether he had gotten a full course of treatment -- had gotten rid of the source of the infection. If the source was still there and the treatment had been stopped, there was still a potential that it could have gone at a later date.

I can't answer that specifically because I

don't really know. I mean, if he had got Vanco and a full course, there is some potential, yes, that if it was from the toe, it might have prevented this. But it was three months later, which is a little bit late. You should have probably expected something a little closer in time as a potential source to see that.

Q. I am not following you. You're saying -- your expectation as to time, what do you mean by that?

A. Well, there usually has to be some source that goes to that area. I suppose it could have been dormant for two and a half months -- that's possible -- and something caused it to stir up. And so it's still possible it could have been seeded at the time of his original infection, if that was the source.

Q. Doctor, what I'm getting at is would Vancomycin being given in early August of 1990 have been a medication that might or could have prevented a similar infection being present in Mr. Hanson's spine three months later?

MS. YOKOYAMA: I would object to the form of the question. You're asking him if Vancomycin had been given in August, and we're not really certain when this infection developed. You're not saying how long it would have been given in August. Are you saying all

the way up until November would it have prevented the infection that was subsequently diagnosed in the back? I think your question leaves a lot of gaps in terms of your hypothetical given, plus there is no foundation as to whether or not Vancomycin should have even been given back in August.

BY MR. MC MAHON:

Q. I'll withdraw the question.

Doctor, if a culture and sensitivity test in August of 1990 had indicated a Methicillin-resistant infection, what would have been a proper course of treatment for that?

A. Well, if it was just localized at the toe, it would have been to amputate the toe. And part of the underlying course of Vancomycin -- I would have given a one or two'week course of Vancomycin, something like that.

Q. What would the Vancomycin do?

A. Because you haven't removed an infected toe, it would just clear any potential infection that might be left at that interface where you're taking the toe off.

Q. Is there any other antibiotic other than Vancomycin that would have been a proper antibiotic if

that was the case?

A. MRSA. That would be the one that you use.

Q. That's it, right?

A. Right.

Q. Now, Doctor, going back my original question in regards to -- I want you to assume, as I said, before that there is a causal connection between the infection in the toe and the spine. Might or could the Vancomycin have prevented a Methicillin-resistant infection in the spine if it was given in August of 1990?

MS. ANDERSON: Are you talking about the two-week course that he described?

BY MR. MC MAHON:

Q. The course you just described, correct?

A. If that's when the seeding occurred, yes, it might have prevented it.

Q. Doctor, are you critical of any of the care that Mr. Hanson received from June 4, 1990, until the present medical care?

A. You keep saying June 4. Is it June 26 or June 4? He was seen by Pina on June 26.

BY MR. MC MAHON:

Q. I'm sorry. Correct.

A. No, I'm not.

Q. Doctor, going back to Dr. Sumyk, you have testified earlier that there was a doctor-patient relationship established between Dr. Sumyk and Mr. Hanson definitely as to those postoperative visits, correct?

A. I don't know how many times he saw him. As I understand it, he saw him once or twice, something like that, and he was covering for Villasuso, as I understand it. How much interaction he had with the patient, whether he actually even saw the patient, is not clear to me. I just know he was covering for him, probably saw him on rounds, and that's all that I know.

Q. Doctor, what is the standard of care in regards to a medical doctor who is seeing a patient on rounds?

A. It's obviously to care for any problems they have at the time. In this case, as a post-op case, it's to check the patency of the graft, to check for -- because they are following the infection of the toe, and make sure that was getting better and was stable; and if there were any other problems, any acute new problems that occurred, to manage those.

Q. Doctor, would a physician have to have an

understanding of a patient's clinical history and current clinical status in order to meet that standard of care?

A. You would have to have some understanding of the patient, yes.

Q. How would he get that?

A. He could have it in this situation by reading the chart, by making rounds. He could have had it from discussions with Dr. Villasuso when it was assigned out to him. He could have it in talking to the patient and examining the patient directly.

Q. You're saying there's a number of different ways he could have met that standard of care?

Is it your testimony that Dr. Sumyk could have met that standard of care as to Mr. Hanson without any review of his chart?

A. Potentially. I mean, that would -- to be complete, but I think potentially if he had gotten a very good summary from Dr. Villasuso and then had examined and seen the patient himself, that could have been accurate.

Q. Generally speaking, though, the method that a doctor uses is to check the chart, correct?

A. Yes.

Q. Are you aware, Doctor, of any conversations or any other type of preparation, as you discussed, as to being an alternative between Dr. Villasuso and Dr. Sumyk prior to his seeing the patient postoperatively?

A. All I know is that he checked out to him on these patients. What discussion there was, I don't know.

Q. What do you mean by that, Doctor, "checked out"?

A. Well, I mean, said he was going to turn these patients over to him while he was either out for the weekend or out of town or whatever it was.

Q. Doctor, assume for the purpose of my question that there was no preparation or communication between Dr. Villasuso and Dr. Sumyk and that Dr. Sumyk did not read Mr. Hanson's chart. Would that be a deviation from the standard of care?

MS. YOKOYAMA: I would object to the form of the question simply because in order for Dr. Sumyk to follow up on this patient -- I mean, there's going to have to be some communications between he and Dr. Villasuso.

BY MR. MC MAHON:

Q. Did you understand my question, Doctor?

A. I understand it, but I -- I mean, if none of those things occurred, I would think that that was not the standard of care.

Q. Just so we're clear, that would be a violation of the standard of c re, correct, Doctor?

A. If you are responsible for the patient, you should know something about them.

Q. Doctor, what actions would the standard of care require as to a doctor such as Dr. Sumyk if he noted in the records that the patient had -- was highly suspicious for osteomyelitis in regards to informing Dr. Villasuso or another doctor?

A. At what point in time?

Q. For those postoperative visits. That's something that he noted in the records.

A. If it's in the record, Dr. Villasuso should know that himself.

Q. You're saying that it would not violate a standard of care not to communicate that to anyone else?

A. I would assume that this is Dr. Villasuso's patient. The X-ray reports are in the chart. And I would think that he would assume that Dr. Villasuso

understands all these things about his own patients. I mean, it's not like it's new information or something that happened while Dr. Villasuso was gone that should have been communicated to him. If something happens new and different while Dr. Villasuso is out of town, that should be communicated to him.

Q. If Dr. Sumyk felt that a bone scan was necessary to rule out spread of osteomyelitis -- assume that for the purpose of my question -- would a standard of care require him to order that test or to do something else?

MS. ANDERSON: This is still for his post-op follow up?

MR. MC MAHON: Correct.

THE WITNESS: I don't think he should have ordered it. I think he would have had to discuss it with Dr. Villasuso.

Do we have much longer?

MR. MC MAHON: I don't, Doctor. Probably five minutes.

BY MR. MC MAHON:

Q. Doctor, what would be the standard of care necessary for that doctor if he felt that a culture and sensitivity was necessary as to the right fifth toe and

none have been done? What would be the appropriate steps that a doctor should take in that circumstance?

A. Well, again, he's not the primary doctor. He would just communicate it to the primary doctor if he thinks -- if he has some thought process about the patient that hasn't been done, he might just communicate it with the primary doctor and see what the primary doctor wants to do.

Q. Doctor, are there any measures that could have been taken with Ken Hanson which could have salvaged his leg between June 26 and November when he goes into the hospital?

A. Well, he had the operation to salvage his leg. He had the toe removed. That was healing. It abscessed, but they opened it and it was healing on the outside. He was making progress. And then after the 31st, the next time, I think, he is seen is the 11th when he mentions the back pain to Dr. Pina, and he was admitted. And at that point in time or shortly thereafter the graft was occluded, so I don't know if there was any -- it was infected at that time.

Q. Doctor, what's your understanding of what the cause of the infection in the graft was?

A. Probably some contamination at the time of

surgery, most likely, since we don't have anything from the foot to indicate there was psuedonomas in the foot.

Q. What's the basis for that opinion, Doctor?

A. Well, again, as I say, 1 can't say for sure. All I know is that it was a pure growth of pseudonomas without other bacteria. Operations -- clean operations such as this have about a 2 percent wound infection rate and about a 1 percent graft infection rate. And he was one of those. And the bugs can be anywhere from staph to E. coli to pseudonomas. It depends on what might have contaminated the surgical site at the time of the surgery. It's usually introduced at the time of the surgery.

Q. Doctor, would you agree with me that 2 percent incident of infection would have been reduced even further if an autogenous graft had been used, rather than a gortex graft?

A. I mean, you may be talking 2 percent down to 1.9 percent.

Q. But the answer is, yes, there would be a reduction in risk?

A. It's not clinically significant.

Q. What do you mean by "clinically significant"?

A. It doesn't make any significance on a

clinical basis, I can't say even it would be make a difference. As I said, there has been no randomized studies to look at the difference.

Q. Would you agree with me, Doctor, that it might make clinical significance to a patient such that it would be something that you would bring up with a patient when you were discussing the risk of procedures?

A. In making a basis between the two different grafts?

Q. Right.

A. I wouldn't because it's a small thing. We would spend all day talking about risks. And this is not a risk that is a difference that you would discuss with a patient.

MR. MC MAHON: I don't have anything else.

MR. BALOS: I have no questions of this witness at this time.

EXAMINATION

BY MR. BROWN:

Q. Just two quick questions.

Doctor, you said earlier in your deposition that you reviewed the record of Westlake Community Hospital which included admission for the bypass

procedure, the removal of the toe, and the infection of the graft in the second amputation, correct?

A. Yes.

Q. Based upon your review of those records, do you have any criticisms of the care and treatment rendered to the plaintiff in this case by the people at Westlake Community Hospital.

A. No, I don't.

MR. BROWN: Thank you.

MR. GARNELLO: I have no questions.

EXAMINATION

BY MR. WHELAN:

Q. I believe you answered this. It's my understanding that you do not have any criticisms of the care and treatment provided to the plaintiff by either Dr. Pina or the Melrose Park Clinic?

A. That's correct.

EXAMINATION

BY MR. BALOS:

Q. Doctor, I have two questions. I would like to show you what's been previously marked as Sumyk Deposition Exhibit No. 7. You referenced that earlier.

MR. MC MAHON: Are you going to mark it?

MR. BALOS: If you want me to mark it, I can mark

MR. GARNELLO: If I can, for the record, is there any deviation -- do you feel there is any deviation with the standard of care from the treatment of Dr. Giachinno at the Melrose Park Clinic sometime on, I think, the 4th or 5th of August of 1990?

THE WITNESS: No.

MR. MC MAHON: I didn't follow. Do you still have that exhibit?

(Discussion off the record.)

MR. MC MAHON: Doctor, have you had any contact with any of the attorneys in the case other than Ms. Yokoyama and Ms. Anderson?

THE WITNESS: No.

MR. MC MAHON: I don't have anything else.

MS. ANDERSON: We'll reserve.

FURTHER DEPONENT SAITH NOT

STATE OF ILLINOIS)
) SS:
COUNTY OF C o o K)

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT - LAW DIVISION

KENNETH HANSON,)
)
Plaintiff,)
vs. No. 92 L 07906
RODOLFO PATINO, M.D., el al.,)
)
Defendants.)

This is to certify that I have read the transcript of my deposition taken in the above-entitled cause by Lucia R. Filippelli, Certified Shorthand Reporter, on the 16th of May, 1995, and that the foregoing transcript accurately states the questions asked and the answers given by me as they now appear.

_____
Fred Nelson Littooy

SUBSCRIBED AND SWORN TO
before me this ____ day
of _____, 1995.

_____
Notary Public

STATE OF ILLINOIS)
) SS:
COUNTY OF COOK)

I, Lucia R. Filippelli, a notary public within and for the County of Cook and State of Illinois, do hereby certify that heretofore, to-wit, on the 16th of May, 1995, Fred Nelson Littooy personally appeared before me at One North LaSalle Street, Suite 3500, in the City of Chicago, in the County of Cook and State of Illinois, a witness in a certain cause now pending and undetermined in the Circuit Court of Cook County, Illinois, wherein Kenneth Hanson is plaintiff and Rodolfo Patino, M.D., et al., are defendants.

I further certify that the said witness was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by said witness was reported stenographically by me, in the presence of the said witness, and afterwards reduced to typewriting by Computer-Aided Transcription, and the foregoing is a true and correct transcript of the testimony so given by said witness as aforesaid.

I further certify that the signature of the witness to the deposition was not waived.

I further certify that the taking of this

deposition was in pursuance of notice; and that there were present at the taking of this deposition the attorneys as hereinbefore noted.

I further certify that I am not counsel for nor in any way related to the parties to this suit, nor am I in any way interested in the outcome thereof.

In testimony whereof I have hereunto set my hand and affixed my notarial seal this 1st day of June, 1995.

" OFFICIAL SEAL "
LUCY R. FILIPPELLI
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 1/7/96

Lucia R. Filippelli

Lucia R. Filippelli, CSR No. 84-3160
Notary Public, Cook County, Illinois

8-9-90 – F/up

8-13 – Office – going [illegible] for

well [illegible]

8-31 – amp
9-4 – Office – cellulitis – Cipro [illegible]
9-11 – " – improved – [illegible] out

9-25 – – A4 coll (R) foot c̄ PD
9-27 – Office – better
10-2 – walked OK
10-9 – [illegible]
10-23 – "
10-31 – much better – RTC – 3 wks

Pain, Patino
6-28-90 – (R) 4th toe – Subungual hematoma.
– Drained it
8-2-90 (R) 5th toe – tender & painful
again – Cipro
8-14-90 – (R) [illegible] ordered – rec. F/up
8-24-90 – (R) 5th toe – no cellulitis, on Cipro

10-23-90 – ↓ 20 lbs. – CBC – SMAC
Foot healing 2° to toe amp
11-11-90 – acute low back pain c̄ lower ext. weakness – admit

Hernan Vi, Villacinco

56 y/o — 6-4-90
(R) 5th toe - trans c gang

8-1-90 — Villacinco consult

gluco - (200)
no hx of DM + hx of claudication

Fem / Pop / DP / PT
(R) 4+ / 0 / 0 / 0
(L) 4+ / pdp / pdp / 0

Alb — (R) CFA occlus at Hunter's canal
tibial level disease - bilaterally —
— (R) AT occluded - ? PT occluded
ankle

8-9-90 — (R) F-AK pop Goretex — Inflow to ankle
— angioplasty — deferred 5th toe area

8-31-90 — (R) 5th toe — MP amp —
closed

on Timentin for antibiotic coverage

11-13-90 — Decompressive laminectomy at graft
11-21-90 — Removal infected F-AK graft closed c
11-28-90 — (R) AK amp —

Alan - Westlake
8-7-90 — FBS - 171 on IV D5W
will follow
— X ray - foot - suspicious for osteo - distal phalanx
8-9-90 — FBS - 134 on IV;

D/C - 8-14-90 on Cipro —
cellulitis of toe - improved.
D/C - on 2000 cal ADA diet
— termed borderline diabetic
no glucose in urine

Toe amp.
Did sign a consent for amp of 5th toe
— done at OP —

154-2314

CURRICULURI VITAE
FRED NELSON LITTOOY, M.D.

Littooy DEP. EX. NO. 1
FOR ID., AS OF 5/16/95

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Positions:

Professor of Surgery, Loyola University Medical Center 1989-

Associate Professor of Surgery, Loyola University Medical Center 1983-1989

Assistant Professor oj Surgery, Loyola Univeisity Medical Center 1977-1983

Chief of Peripheral Vascular Surgery, Hines V.A. Hospital 1980-

Assistant Chief of Peripheral Vascular Surgery, Hiiies Y.A. Hospital 1977-1980

Clinical Instructor in Surgery, Univ. of California San Fraiicisco 1976-1977

Post Graduate **Training:**

Fellow in Vascular Surgery, UCSF (Edwin J. Wylie) 1976-1977

Chief Residerit, General Surgery, UCSF (Paul A. Ebert) 1975-1976

Senior Resideiit, Geiieral Surgery. UCSF (J.E. Dunphy) 1974-1975

Research Fellow, Wound Healing Laboratory, UCSF (Thomas K. Hunt) 1972-1974

Clinical Fellow, American Cancer Society, UCSF 1972-1973

Clinical Fellow, Melanoma Clinical Cooperative Study, UCSF 1972-1973

Junior Resideiit. General Surgery, UCSF (J.E. Dunphy) 1970-1972

Straight Surgical Internship, UCSF (J.E. Dunphy) 1969-1970

Education:

University of Kansas School of Mediciiie, M.D. 1969

University of Kaiisas, A.B. 1965

German Summer Language Institute, Munich, Germany (Univ. of Kansas) 1963

Honors, Scholarships, and Certifications:

Certification by American Board of Surgery 1977

Recertification by American Board of Surgery 1989

Certification of Special Qualifications in Vascular Surgery by American Board of Surgery 1983

NIH Training Grant, UCSF 1972-1976

Alpha Omega Alpha, University of Kaiisas School of Mediciiie 1968

Sachem, Men's Honor Society, University of Kansas 1965

University of Kansas Honor Scholarships 1961-1965

Research Positions:

Co-Investigator: Wyeth Ayerst Research Protocol number 622A-209-U5; "Comparison of The Efficacy & Safely of Subcutaiieous RD/Heparin vs. Subcutaneous Unfractionated Heparin for The Prevention of Deep Venous Thrombosis in Patients Undergoing Abdoniiiial or Pelvic Surgery for Cancer" 1989 -

Priiicipal Investigator: VA Cooperative Study #309: "The Role of Carotid Endarterectomy in Preventing Stroke from Symptomatic Carotid Stenosis" 1589 - 1991

Priiicipal Investigator: "Asymptomatic Carotid Atherosclerosis Study" USPHS NIH NINCOS 2 RO1 N5-22611-03 1989 -

Priiicipal Investigator: VA Cooperative Study #141: "Efficacy of Vascular Graft Materials in Lower Extremities by Revascularization" 1983 - 1991

Priiicipal Investigator: VA Cooperative Study #199: "Percutaneous Transluminal Angioplasty of the Lower Extremity" 1983 - 1989

Priiicipal Investigator: VA Cooperative Study #362: "Oral Anticoagulant Therapy to Improve Patency of Small Caliber Prosthetic Bypass Grafts" 1991 -

Co-Investigator: NIH-North American Symptomatic Carotid Endarterectomy Trial (NASCET) 1991 -

Priiicipal Investigator: VA Cooperative Study #379: "The Aneurysm Detection and Management (ADAM) Study" 1992 -

Member of Medical and Surgical Societies:

Alpha Omega Alpha Honor Medical Society 1968

Naffziger Surgical Society 1976

Associatioii for Academic Surgery 1977

Midwestern Vascular Surgical Society 1979

International Society for Cardiovascular Surgery 1979

American College of Surgeoiis, Fellow 1980

National Association of VA Physicians 1980

Illinois Surgical Society 1981

Association of Veterans Administration Surgeons 1981

Chicago Surgical Society 1981

Midwest Surgical Associatioii 1984

Central Surgical Association 1987

Western Surgical Association 1987

Society for Vascular Surgery 1987

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32. LXTTOOY FN *and Baker WH: Aortic aneurysm aiid aortocaval fistula: diagnosis aiid intraoperative management. Seminars in Vascular Surgery. 1988: 1:182-187.*

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36. LITTOOY FN, *Steffan G, Greisler HP, White TL, aiid Baker WH: Use of sequential b-mode ultrasonography to manage abdominal aortic aneurysm. Arch Surg. 1989; 124:419-421.*

37. *Pinzur MS,* LITTOOY FN, *Osterman* **H,** *arid Schwartz D: A safe, pre-fabricated, immediate postoperative prosthetic limb system for rehabilitation of below-knee amputation. Orthopedics. 1989; 12:1343-1345.*

38. LITTOOY FN: *Meeting Highlights; Thirteenth Annual Meeting of the Midwestern Vascular Surgical Society. Vascular Surgery Outlook. 1989; 1:3-8.*

39. *Ablan CJ,* LITTOOY FN, *arid Freeark RJ: Postoperative chylous ascites: diagnosis aiid treatment. Arch Surg. 1990; 125:270-273.*

40. *Whereatt NE, Burke K,* LITTOOY FN, *Greisler NP, and Baker WH: An Evaluation of External Jugular Vein Patch Angioplasty after Carotid Endarterectomy. The American Surgeon. 1990; 56:455-459.*

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44. *Springhorn ME, Kinney M.* LITTOOY FN, *Saletta C. aiid Greisler HP: Inflow Atherosclerotic Disease Localized to the Common Femoral Artery: Treatment and Outcome. Annals of Vascular Surgery. Annals of Vasc Surg. 1991; 5:234-240.*

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I. **LITTOOY** FN, *Fuchs R, Huiit TK aiid Sheldoii GS: Tissue oxygen as a real-time measure of oxygen transport. Abstracted on* **pg.** *33 of 1977 Year Book of Surgery. Edited by* **S.** *Schwartz. Year Book Medical Publishers, Inc., Chicago-London, 1977.*

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1. LITTOOY FN: *Use of sequential b-mode ultrasonography io manage abdominal aortic aneurysms. Arch of Surg. 1559; 124:1464.*

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1. *Hunt TK and* LITTOOY FN: *Physiology aiid Management of Wounds. Brief textbook of Surgery, edited by C.P. Artz. I. Cohn, Jr., J.H. Davis. W.B. Saunders Co., Philadelphia, 1976. pp. 1-18.*

2. LITTOOY FN: *Cerebrovascular Insufficiency Understanding aird Recognition. Chapter 1. In: Diagnosis aiid Treatment of Carotid Artery Disease edited by W.H. Baker, M.D., Futura Publishing Co., Mount Kisco. New York, 1979. pp. 1-27.*

3. LITTOOY FN *and Baker WH: Major Arteriovenous Fistulas of the Aortic Territory. In: Surgery of the Aorta aiid Its Body Branches. edited by Drs. John J. Bergan aiid James S.T. Yao, Grune & Stratton. New York, 1975. pp. 605-619.*

4. LITTOOY FN *and Huiit TK: Wound Healing. In: Otolaryngology edited by Michael M. Paparella, M.D. arid Donald Shumrick, M.D., W.B. Saunders Co., Philadelphia, 1980, pp. 650-657.*

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7. LITTOOY FN *aiid Baker WH: Excision of Carotid Aneurysm. In: Mastery of Surgery, Vol. II, Edited by Lloyd M. Nyhus aird Robert J. Baker, Little Brown aiid Co., 1984, pp I411-1418.*

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9. LITTOOY FN *aird Baker WH: Ruptured Abdominal Aortic Aneurysm. In: Complications in Vascular Surgery. edited by V.M. Bernard aiid J.B. Towne, Grune aird Stratton, Orlando, FL 1985, pp. 121-142.*

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10. LITTOOY FN *and Baker WH: The Use of Lumbar Sympathectomy in Lower Extremity Vascular Disease. In: Vascular Surgery of the Lower Extremity. Edited by Jarrett, F., Hirsch, S. C.V. Mosby Co., St. Louis, MO 1985, pp 184-191.*

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13. *Freeark R and* LITTOOY FN: *Vascular Trauma. In: Operative Surgery Principles and Techniques. Edited by Nora, PF. W. B. Saunders Company., 1990, pp 1017-1030.*

14. *Dobrin PB and* LITTOOY FN: *Arterial Injuries Caused by Balloon Catheter Embolectomy: Causes arid Prevention. In: Iatrogenic Vascular Injury: A Discourse on Surgical Techiiiaue. Edited by Bunt, TJ, Futura Publishing Co.. 1990, pp 101-125.*

1.5. LITTOOY FN: *Acute Infrarenal Aortic Thrombosis. In: Current Therapy in Vascular Surgery. Edited by Ernst CB aiid Stanley JC, BC Decker, Inc.. 1990, pp 410-413.*

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Book Review:

1. *"Acute peripheral vascular surgery" by Michael Standacher. J Vascular Surg. 4: 538, 1986.*

Exhibits:

1. *"Multiple Method Non-Invasive Cerebrovascular Testing". Presented at American College of Surgeons, October, 1978, aiid American College of Cardiology. March, 1579.*

2. *"Reoperation after Complications of Aortoiliofemoral Inflow Procedures". Poster presentation at The Associatioil of Veterans Administration Surgeons, Atlanta, Georgia. May 13-1.5, 1982.*

3. *"Improved Results in Carotid Endarterectomy with Selective Shunting". Preseiifed at the Eighth Annual Surgical Symposium Assoc. of VA Surgeons, Los Angeles, California. May 9-12, 1984.*

4. *"Carotid Surgery in Patieiits with Acute Stroke". Presented at the Eighth Annual Surgical*

Symposium Assoc. of VA Surgeons, Los Angeles, California. May 9-12, 1984.

Presentations:

1. *"Tissue Oxygen as a Real-Time Measure of Oxygen Transport". Associatioil for Academic Surgery, Miiiiieapolis, Minnesota. November 1975.*

2. *"Retial Artery Thromboendarterectomy". Midwestern Vascular Society, Chicago, Illinois. September 1577.*

3. *"Vascular Injuries Secoiidary to Blunt Trauma". Chicago Committee on Trauma, American College of Surgeons Trauma Conference, Chicago, Illiiiois. December 1977.*

4. *"Abdoniiiial Aortic Aneurysm". Combined Surgical Grand Rounds (Cook County Hospital, Metropolitan Group of Hospital. University of Illinois aiid West Side V.A.), Chicago, Illiiiois. April 1978.*

5. *"Aortic Aneurysm". Weiss Memorial Hospital, Chicago, Illiiiois. May 1978.*

6. *"Laparotomy as a Precipitating Factor in the Rupture of Intra-Abdominal Aneurysm". Society of Vascular Surgery. Nashville, Tennessee. Juiie 1979. (Presented by R.J. Swanson)*

7. *"Femoral-Isolated Popliteal Bypass: Selected Use in Severe Limb Ischemia". Midwest Surgical Society, Lincolnshire, Illiiiois. August 1579. (Presented by Charles Saletta)*

8. *"The Management oj Polytetraflouroethylene (PTFE) Graft Occlusions". Western Surgical, Denver, Colorado. November 1979. (Preseiited by M. Margaret Hadcock)*

9. *"Major Arteriovenous Fistulas of rhe Aortic Territory". Symposium on Surgery of the Aorta aiid Its Body Braiiches. Chicago, Illiiiois. December 1979.*

10. *"Outcome of Patients with Combined Coronary aiid Peripheral Atherosclerosis". Society of University Surgeons, Houston, Texas. February 1980. (Preseirted by George Childs)*

11. *"Immediate aiid Long Term Outcome of Acute Arterial Occlusioii of the Extremities: The Effect of Added Vascular-Reconstruction". The Associatioil of V.A. Surgeons. Minneapolis, Minnesota. May 1981. (Presented by Timothy Fieldj*

12. *"Indications aiid Methods for Vena Cava Interruption". Chicago Medical Sociely 37th Annual Conference, Chicago, Illiiiois. May 1981.*

13. *Round Table Discussioii on "Surgery". Chicago Medical Society 37th Annual Conference, Chicago, Illiiiois. May 1981.*

14. *"Complications of Amputations in the Diaheric Patient". Northlake Surgical Seminar, Northlake, Illiiiois. May 1981.*

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15. *"Amputation of the Foot in the Diabetic Patient". Northlake Surgical Seminar, Northlake, Illinois. May 1981.*

16. *"Amputation of the Leg in the Diabetic Patient". Northlake Surgical Seminar, Northlake, Illinois. May 1981.*

17. *"Complications of Treatment of Vascular Injuries of the Lower Extremity". Northlake Surgical Seminar, Northlake. Illiiiois. May 1981.*

18. *"Intimal Hyperplasia aiid Medial Thickening in Autogenous Vein Bypass Grafts: Influence of Anastomoses arrd Platelet-Inhibiting Drugs". The Association for Academic Surgery, Chicago, Illiiiois. November 1981.*

19. *"Acute Visceral Ischemia". West Suburban Hospital, Oak Park, Illiiiois. September 1982.*

20. *"Continuous Wave Doppler Assessment of Carotid Arteries: Is it Reproducible?" San Diego Symposium on Noninvasive Diagnostic Techniques in Vascular Disease. San Diego, California. October 1982. (Preseiited by Andrew C. Hayes)*

21. *"Factors Influencing Morbidity of Carotid Endarterectomy Without a Shunt". Midwest Surgical Associatioir 25th Annual Meeting. Huron, Ohio. August 1983.*

22. *"External Carotid Revascularization - Correlation of Indications arid Results". Midwest Surgical Association 25th Annual Meeting, Huron, Ohio. August 1983. (Presented by Kevin Halstuk, M.D.).*

23. *Panelist: "Heparin. Warfarin. aiid Thrombolytic Therapy". Midwest Surgical Association Aiiiiual Meeting. Huron. Ohio. August 1983.*

24. *"External Carotid Revascularization - Correlation of Indication and Results". Midwestern Vascular Surgical Society Seventh Aiiiiual Meeting, Chicago, Illinois. September 1983. (Presented by Kevin Halstuk. M.D.)*

25. *Panelist: "Carotid Reconstruction". Midwestern Vascular Surgical Society Seventh Annual Meeting, Chicago. Illiiiois. September 1983.*

26. *"Management of Patieiits with Aortic Aneurysms: Infrainguinal, Supra-inguinal aiid Thoracoabdominal". The Cook County Graduate School of Medicine Specially Review in Vascular Surgery. Chicago, Illinois. November 1983.*

27. *"Acute Arterial Thromboembolism". The Cook County Graduate School of Mediciiie Specialty Review in Vascular Surgery. Chicago, Illiiiois. November 1983.*

28. *"Intra-arterial Subtraction Angiography as a Method to Study Peripheral Vascular Disease" Midwestern Vascular Surgery Meeting. Columbus, Ohio. September 1984. (Preseiited by Bradford Blakeman, M.D.)*

29. *"Anastomotic Pseudoaneurysms: A Continuing Late Complication of Vascular Reconstructive Procedures Association of VA Surgeons. Tampa, Florida. May 1985. (Preseiited by James Dennis. M.D.)*

30. "Pneumatic Compression Devices in Prophylaxis of Deep Venous Thrombosis (DVT). Midwest Surgical Associatioii. Lake Geneva, Wisconsin. August 18-21, 1985. (Presented by William H. Baker, M.D.)

31. "Acute Aortic Occlusion - A Multi-Faceted Catastrophe. Midwest Surgical Association. Lake Geneva, Wisconsin. August 18-21, 1985.

32. "Acute Aortic Occlusioii - A Multi-Faceted Catastrophe. Midwestern Vascular Society. Chicago, Illinois. September 1985.

33. "Medicate for Today: Update on Peripheral Vascular Surgery". Illinois Academy of Family Physicians Postgraduate Program. Oak Brook, Illiiiois. March 1986.

34. "Effect of Prior Arterial Reconstruction on the Outcome of Femorofemoral Bypass". Midwest Surgical Association. Mackinac Island, Michigan. August 1936. (Presented by Katherine A. Widerborg, M.D.)

35. "Redo Vascular Procedures for Lower Extremity Ischemia-A Dilemma". Midwestern Vascular Surgical Society. Indianapolis, Indiana. September 1936. (Presented by James W. Dennis, MD)

36. "Comparative Evaluation of Prosthetic. Reversed, aiid In Situ Bypass Grafts in Distal Popliteal aird Tibial/Peroneal Revascularization" Association of VA Surgeoiis. Portland, Oregon. May 1987. (Presented by Willard C. Johiisoii. M.D.).

37. Panelist: "Management of Thoracic Inlet aiid Neck Wounds" The Secoiid Aiiiiual Conference for The Directors of Surgery in Chicago. Rosemont, Illiiiois. November 1987.

38. "Mechanical Factors Predisposing to Intimal Hyperplasia aiid Medial Thickening in Autogenous Vein Grafts." Association for Academic Surgery. Orlando, Florida. November 1987. (Preseiited by Philip B. Dobrin, M.D.).

39. "Results of the Management of Veteran Patieiits with Abdominal Aortic Aneurysms Over a 10-Year Period." Associatioil of VA Surgeons. Miiiiieapolis, Minnesota. May 1988.

40. "Percutaneous Transluminal Aiigioplasty Versus Bypass Surgery for Peripheral Arteriosclerosis: A Four Year Report." The Society for Vascular Surgery. Chicago, Illinois. June 1988. (Presented by Samuel F. Wilson, MD).

41. "Peripheral Vascular Disease - DVT aird Arterial Occlusioii." Medicine For Today. Winfield, Illiiiois. October 1988.

42. "Assessment of the Dysvascular Amputee" Prosthetic/Orthotic Course. Hiiies VA Hospital, Hiiies, Illinois. November 1988.

43. "Postoperative Chylous Ascites Diagnosis aiid Treatment: A series report aiid literature review" Chicago Surgical Society, Chicago. Illiiiois. February 1989.

44. "Advances in Vascular Surgery: New Developments aiid Practical Considerations" University of Illinois, Cook County Graduate Scliool, Chicago, Illinois. March 1989.

45. "Natural History of Asymptomatic Carotid Bruits" Association of VA Surgeons, San Antonio, Texas. May 1989 (Presented by Eric D. Endean, MD).

46. "An Evaluation of External Jugular Vein Patch Angioplasty after Carotid Endarterectomy" Midwest Surgical Associatioii, Kohler, WI. August 1959 (Preseiited by Nancy E. Whereatt, MD).

47. "Inflow Atherosclerotic Disease Localized to the Common Femoral Artery: An Unusual Entity: Midwestern Vascular Surgical Society, Chicago, Illinois. September 1989 (Presented by Mary E. Springhorn, MD).

48. "Recognition and Management of Acute Arterial Occlusioii". Regional Vascular Conference, University of Wisconsin School of Mediciiie, Madison, Wisconsin. November 1989.

49. "Management of Peripheral Vascular Disease". Thirteenth Annual Midwest Regional "Primary Care Update", Illinois Academy of Physician Assistants, Hyatt Oakbrook, Oakbrook, Illiiiois. November 1989.

50. Moderator: Panel discussion; Extra-Anatomical Bypass. Techniques in Arterial Surgery, Northwestern University Symposium, Chicago, Illiiiois. December 1989.

51. "Portasystemic Shunting". Loyola University Stritch School of Mediciiie, Surgical Grand Rounds, Maywood. Illinois. January 1990.

52. "Acute Arterial Occlusioir", University of Florida Health Science Center, Surgical Grand Rounds, Jacksonville. Florida. February 1590.

53. "Acute Aortic Occlusioii". Jacksonrille Vascular Society Meeting, University Club, Gulf Lake Towers, Jacksonville. Florida. February 1950.

54. "Surgical Case Presentations", Gore-Tex Medical Products. Edmond, Oklahoma. July 1950.

55. "Splanchnic Arterial arid Venous Disease" Speciality Review in General Surgery - Part I, University of Illinois Cook County Graduate School. Augusi 1990.

56. "An eleven year experience with aortofemoral bypass grafting", Midwestern Vascular Surgical Society Meeting, Toledo, Ohio. September 1590.

57. "Aorto - Iliac Reconstruction" aiid "Small Vessel Reconstruction, In-Situ Grafting", Loyola University Medical Center, The Diabetic Foot: Methods for Preservation aiid Salvage. Oak Brook Hills, Illinois. October 1990.

58. "Acute Mesenteric Ischemia", Medical Grand Rounds, Hities VA Hospital, Hiiies, Illiiiois. October 1990.

59. "Portal Hypertension, Thromboembolism, aiid Venous Stasis" Speciality Review in General Surgery, Part II, The Cook County Graduate School, Chicago, Illiiiois. November 1990.

60. "Arterial arid Venous Insufficiency: Current Management" Advances in Family Medicine, The Cook County Graduate School, Chicago, Illiiiois. March 1991.

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61. *"Advances in Arterial and Venous Surgery" - Review in Family Practice, The Cook County Graduate School, Chicago, Illinois. March 1991.*

62. *Guest Lecturer. "Small Abdominal Aortic Aneurysm - When to Operate?" Cleveland Vascular Society, Cleveland, Ohio. April 1991.*

63. *Presidential Address: "Initiation of The Vascular Fellow: A Major Challenge for Vascular Surgery Educators". Midwestern Vascular Surgical Society, Chicago, Illiiiois. September 1991.*

64. *Anastomotic Workshop. Sponsored by Impra, Inc. April 8, 1992.*

65. *"Outcome of Femoral Popliteal Bypass, Ramathi badi Hospital, Mahidol University, Bangkok, Thailaiid. April 9, 1992. Sponsored by Impra, Inc.*

66. *"Outcome of Femoral Popliteal Bypass. Siriraj Hospital. Mahidol University, Baiigkok, Thailand. April 10, 1992. Sponsored by Impra, Inc.*

67. *"Outcome of Femoral Popliteal Bypass. National University Hospiial, Singapore. April 15, 1992. Sponsored by Impra, Inc.*

68. *"The Case for Preferential Use of Reverse Saphenous Vein for Above Knee Femoropopliteal Bypass in Patients with Good Runojj". Association of VA Surgeons. Albuquerque New Mexico, May 1992. (Preseiited by Gregory C. Zenni, MD)*

69. *Johnson WC, Lee KK, Bartle E, Corson JD, Curl GR, Fowl R, Gutierrez IZ, Johnson G,* LITTOOY FN, *et al: Comparative Evaluation of PTFE, HUV, aiid Saphenous Vein Bypasses in Fem-Pop AK Vascular Reconstruction. VA Cooperative Study Group #141. Presented at the 40th Annual Meeting of The International Society for Cardiovascular Surgery, North American Chapter. Chicago Illinois. Juiie 1552.*

70. *Wilson SE, Mayberg MR, Yatsu F.* LITTOOY FN, *aiid Weiss DG: Crescendo TIA's: A Surgical Iniperative. VA Cooperative Study 309 Trialists. Preseiited at the 40th Annual Meeting of The International Society for Cardiovascular Surgery, North American Chapter. Chicago Illinois. June 1992.*

71. LITTOOY FN: *Peripheral Neurovascular Syndromes. Speciality Review in Surgical Critical Care. The National Center for Advanced Medical Education. Chicago Illinois. July 1992.*

72. LITTOOY FN: *Nonthoracic Vascular Disease. Speciality Review in Surgical Critical Care. The National Center for Advanced Medical Educatioii. Chicago Illinois. July 1992.*

73. *"Femoral-Tibial Bypass with In Situ Techniques". American College of Surgeons. New Orleaiis, Louisiaiia. October 1992.*

74. *Panel Discussioii; Revascularization of the Lower Extremities. American College of Surgeons, New Orleaiis, Louisiaiia. October 1992.*

75. *Panel Discussioii; "Changing Patterns in the Care of Lower Limb Ischemia". Mount Carmel Health Peripheral Vascular Disease Symposium. Columbus, Ohio. October 1592.*

76. *Moderator: "Long-term results of thoracic aorta reconstructions". Northwestern University Vascular Surgery Symposium, Chicago, Illiiiois. December 1952.*

77. *Panel Disscussion: "Long-term results of thoracic aorta reconstructions". Northwestern University Vascular Surgery Symposium, Chicago, Illiiiois. December 1992.*

78. *"What a vascular lab can do for the general surgeon". Aiiiiual Clinical Meeting of The Illiiiois Surgical Society, Inc. Maywood, Illinois. May 1993.*

79. *"Intraoperative duplex scanning aird late carotid stenosis". Midwestern Vascular Surgical Society, Chicago, Illiiiois. September 1593.*

80. *"The small aortic aneurysm with updates on aneurysmal disease". Insights into Peripheral Vascular Disease" Symposium. Columbus, Ohio. October 1993.*

Committees:

Professional Standards Review Committee 1979-1981

Medical School Admissions Committee 1980-1981

Merit Review Committee (Hines VA Hospital) 1980-1985

Surgical Research Committee/Committee on the Core Animal Surgical Unit 1981-

Quality Assurance Steering Committee 1982-

Professional Standards Review Committee (Chairman) 1982-1985

Research arid Development Committee (Hiiies VA Hospital) 1982-1985

Physician Advisor for Medical District r17 (Hiiies VA Hospital) 1985-

Chicago Surgical Society Membership Committee 1936

QM Surgical Representative, Hiiies VA Hospital, 1989 -

Operating Room Committee, Hiiies VA Hospital, 1991 -

National Committee Appointments:

Executive Committee of VA Cooperative Study #362 1991 -

Executive Committee of VA Cooperative Study #141 1984 - 1991

Midwestern Vascular Surgical Society, Local Arrangements Committee 1983, 1985

Executive Committee of VA Cooperative Study #199 1985 - 1990

***Mid**western Vascular Surgical Sociely, Treasurer 1985 - 1988*

Executive Committee of Midwestern Vascular Surgical Society, 1985 - 1988

Executive Committee of the Cardiovascular Institute, 1985 -

Committee of Allied Health, Education, and Accreditation (CAHEA) for The Society for Vascular Surgery, 1990 -

Executive Committee of Midwestern Vascular Surgical Society, 1990 - I992

Planning Committee for VA Cooperative Study on Treatment of Small Abdominal Aortic Aneurysms, 1990 -

Executive Committee for VA Cooperative Study #379, 1992 -

President-Elect, Midwestern Vascular Surgical Society, 1990

Courzcilor, Midwest Surgical Association, 1990 -

Presidelit, Midwestern Vascular Surgical Sociely, 199I

Visiting Professorships:

1. *Visiting Professor. "Extra Anatomic Bypass: Indications, Selection Criteria, aiid Results" The University of Illinois College of Mediciiie. Chicago, Illinois. December 11, 1985.*

2. *Visiting Professor. University of Florida Health Science Center, Jacksonville, Florida. February 22, 1990.*

3. *Visiting Professor. "Acute Arterial Occlusioii". University of Wisconsin School of Mediciiie, Madison, Wisconsin. November 15, 1990.*

4. *Visiting Professor. "Management of The Small Abdominal Aortic Aneurysm". University of Kaiisas School of Medicine, Wichita, Kaiisas. May 12-13, 1992.*