Re Donald C. Man (04/25/89)

This deposition was delivered to C.A.T.A. with the following pages missing

Pages 24 to 28

Pages _____ to _____

Pages _____ to _____

#637

IN THE COURT OF COMMON PLEAS

OF CUYAHOGA COUNTY, OHIO

KATHLEEN M. NABOZNY,

Plaintiff,

vs.

Case No.

WILLIAM E. CHEPLA, D.D.S.,

131627

Defendant.

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Deposition of DONALD C. MANN, M.D., a witness herein, called by the Plaintiff for examination under the statute, taken before me, Tia G. Moseley, a Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel, at the offices of Donald C. Mann, M.D., 1611 South Green Road, South Euclid, Ohio, on Tuesday, April 25th, 1989, at 4:30 o'clock p.m.

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ORIGINA

RETURN TO
PAUL KAUFMAN
1600 MIDLAND
BLDG

APPEARANCES:

On behalf of the Plaintiff:

Kaufman & Cumberland, by

FRANK R. DeSANTIS, ESQ.

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861-0707

On behalf of the Defendant:

Kitchen, Messner & Decry, by

EUGENE B. MEADOR, ESQ.

1100 Illuminating Building

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241-5614

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AFTERNOON - SESSION

BY-MR.

DONALD C. MANN, M.D:

BY-MR. DeDANTIS: Q.

MARK'D

Exhibit 1 was mark'd for purposes of
Exhibits 2 and 3 were mark'd for purposes of
Exhibit 4 was mark'd u for purposes of
Exhibit 5 was mark'd for purposes of

MR. DeDANTIS: Swear in the witness. ple

DONALD C. MANN, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF DONALD C. MANN, M.D.

BY-MR. DeDANTIS:

Q. Could you state your name, please, for the record.

A. Donald Charles Mann.

Q. And your address?

A. 1611 South Green Road in the suburb of South Euclid.

Q. Have you ever been deposed before?

A. I have.

Q. So you're generally familiar with the mechanics of depositions but let me just go over for a minute, you have to answer. verbally, as you know, a nod of the head or an uh-huh is difficult for the court reporter to reflect.

Also, may name is Frank DeSantis and I represent the plaintiff in this case and I'm going to be asking you a series of

questions.

Recognize that I do not have a medical background, so that if any of my questions are not understandable, either because of my syntax or because of my lack of medical training, please feel free to correct me or to ask me to restate it in a fashion that's understandable.

If you answer my questions, I'll assume that you understand them.

A. Okay.

Q. Additionally, if ai. any time you want to break, just let me know. If at any time you want to go off the record, just. let me know, feel free to do that at your convenience.

Could you state your profession, please.

A. I'm a physician.

Q. Do you have a specialty?

A. I do.

Q. What is that?

A. That's neurology.

Q. Are you board certified?

A. I am.

Q. Are you board certified in any

other specialty?

A. I'm not.

Q. Where do you currently have hospital privileges?

A. University Hospitals of Cleveland, Cleveland Metropolitan General Hospital, now called Metro Health, and Geauga Community Hospital.

MR. DeDANTIS: Mark this, please.

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(Thereupon, Plaintiff's MANN Deposition Exhibit 1 was mark'd for purposes of identification.)

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Q. Doctor, I've handed you what's been marked as Plaintiff's MANN Exhibit 1, which I believe is your resume.

A. It is, yes.

Q. Curriculum vitae?

A. Yes, it is.

Q. I know it says 1989 at the top but I just want to make sure, is that the most current CV?

A. Yes, it is.

Q. I believe it says that you're

currently an associate clinical processor of neurology at Case-Western?

A. Correct.

Q. What courses do you teach there?

A. Well, my teaching at Case has largely to do with graduate physicians, residents, and these are men and women who already have medical degrees and are learning specialty training and so supervision of their work with patients, their histories, their physicals, what treatments they suggest, and so forth, is largely the kind of thing I do in terms of education rather than classroom material.

Q Rut I presume that the general subject matter is neurology?

A Yes, very specifically, I teach neurology to residents in medicine and neurological diseases of the nervous system. treatments, management of patients and things of that nature.

Q. Have you ever taught any courses which had as a part of the subject matter of the course the diagnosis or treatment of pterygopalatine fossa infection?

A. I have not taught a course like that, no.

Q. Have you ever lectured or taught courses to dentists or students training to be dentists?

A. When I first came to Cleveland, I gave one or two lectures to the undergraduate dentists that had to do with neurology.

Q. And do you have a private practice?

A. I do.

Q. And your private practice is located here at University Suburban Health Center?

A. Yes, it is.

Q. What percentage of your time is devoted to private practice as opposed to teaching?

A. Well, 90 percent of my time is with patients and approximately the other 10 percent is administrative things or hospital work arid things of that: nature.

Q. What do you mean by administrative, doctor?

A. Well, there is a certain amount of

chart work that has to be done in every institution.

I do some departmental work for the department of neurology at University Hospitals which involves committee meetings and notes and that type of thing, so if you add all those little things up, it comes to around 10 percent of my time.

Q. And do you include your teaching at Case with the 90 percent with patients or the 10 percent administrative?

A. I would include it with the 10 percent administrative.

Q. Directing your attention to the CV, coordinator CME, University Hospitals, what does coordinator CME mean?

A. Continuing medical education.

Q. What does that involve?

A. Well, that actually was a time when I was working for University Hospitals and doing more administrative work and I was then arranging courses for graduate physicians, these are physicians in practice now who needed or desired access to certain types of updates, certain types of ongoing conferences that take

place at University Hospitals and I worked in that capacity also at the medical school where I was an associate in the CME office, but that refers to education for physicians in practice, basically.

Q. In your private practice, have you ever diagnosed or treated a patient suffering with pterygopalatine fossa infection?

A. I have not.

Q. Can you explain to me what pterygopalatine fossa infection is?

A. Yes. The pterygopalatine, that is a very specific anatomic term that refers to the bones that extend behind the cheek and down from the base of the skull into what is the portion above the palate and mouth and through that; area traverse veins and arteries with their muscles and nerves as well and the pterygopalatine space is bounded by bone on one side, muscle on another and that space may exist; just in the anatomy, although there is no space there until you start to pry into *it* or an abscess develops.

That type of potential space is called a fossa, so that's where the term fossa

conies from, you have a lot of potential spaces in the body that aren't occupied until something goes wrong like a hernia, for instance, so that: the pterygopalatine space i.s located, as I said, behind the cheek arid that space or fossa can be occupied by fluid, for instance, if there was edema, a tumor, can work its way through there, there could be bleeding there if a vessel were ruptured or there were an injury, say a penetrating injury of the face, or an infection can occur there, so an infection i.s another one of the agents that can occupy that space and by infection we mean virus or bacteria or sometimes there are fungal infections of the face, in diabetics, for instance, that can occupy that section of the face.

Q. What would cause an infection in that area?

A. Well, the infections in the spaces about the face, as opposed to say within the brain, like meningitis, are caused by a number of different sources, they can arise spontaneously, they can just be sort of acts of God, you can get an infection below the eye or

behind the eye in the space there, just for no reason at all, that's unusual.

Some infections occur in patients who have diminished ability to tight infections, patients who have cancer, who are on immune suppression treatment or patients with tumors of the infection fighting part of the blood, such as lymphoma, a foreign body in a space, a fragment of glass or metal say as occurs in explosions can break down barriors and you can actually carry the infection in there.

The structures in the adjacent area can be a source of infection. The maxillary sinus, which is open to the air and can get organisms in it, one can get an infection there and it can extend right through the bone if it is a virulent enough infection os the teeth or the pharynx where there are other spaces that are open to the air, infection can get root and travel either locally by crawling along things or be carried in the blood to that space, so those are basically the mechanisms by which infection can arise in the spaces around the brain.

Q. You mentioned the act of God. Is that a possibility in the pterygopalatine fossa?

A. This is a rare thing and I just think that's highly unlikely to occur there. You probably should strike that one.

Q. No, I just wanted to make it clear. I understand what you're saying.

What would be the symptoms of the pterygopalatine fossa abscess?

A. Pain would probably be one of the leading symptoms because you're stretching delicate structures that are sensitive to start with, the face being probably the most exquisitely sensitive part of the body, highly innervated, highly protected against damage, so that excruciating severe pain would be one of the early symptoms.

Along there as the nerves are affected there would be sensory symptoms because there are sensory nerves that traverse that space that go to the face, they come through and innervate the cheek and the lip and the tongue arid as the infection spreads back towards the major trunk of the nerve, you might

see more numbness as the nerve trunk itself becomes involved, so numbness is another one.

If the nerve trunk itself becomes involved, and now you're talking about moving into the brain substance itself, you can get weakness of the jaw muscle on that side, other nerve symptoms since other nerves start to yet into the picture at that level that move eyes and so forth.

Q. You mentioned pain as a possible symptom of pterygopalatine fossa abscess. Where would that pain manifest itself or where would you expect that pain to manifest itself?

A. I'd expect it to be largely in the cheek area around the, next to the nose, a patient may say it's behind the nose, it's above the jaw, above the teeth, but sometimes pain is referred, that is, it is felt. downstream from where it is so that you could have teeth pain, palate pain, the roof of the mouth, for instance, I suppose you could even conceivably have pain in the throat, the pharynx, but most of it. should be sight in the face and T would expect that would be where most of the patients who have this would talk

about their pain.

S· Closer to the nose? Would you expect it at: all closer to the ear?

A. I would think it would be eloser to the front of the face since the space is a little closer there but. again you can yet pain that's referred, particularly as we move back towards the nerve trunk, the headquarters of the nerve, there are twigs khat go to the ear, so you could have pain in the jaw itself but again, niost of it would be sort of towards the front of the face. The location of the pain isn't as much of a clue I think as the intensity of the pain.

Q. Does your practice involve diagnosis of deep facial infections?

A. I have in my practice under unusual circumstances diagnosed that type of infection but they are rather rare and they don't arise very much in the routine day-to-day sort of situation where I see patients that walk in and make appointments, they are usually done in advance but if somebody had something that was acute and I saw them, I would expect myself to be able to formulate a diagnosis or be

suspicious of it but; it's not something I do every day by any means.

Q. You said they are usually done in advance. Do you mean the diagnoses are usually done in advance?

A. No, a patient usually sets up an appointment and may have to wait days or a week or so, so a patient with a deep facial infection isn't going to wait days or a week to see me usually, so the nature of my practice is structured so that I may not see such patients, they might go to emergency rooms or other sources of medical care.

Q. Is it part of your practice to treat deep facial infections?

A. As they arise, yes, I mean if I have a patient who has something of this nature, I certainly would treat such a patient, yes.

Q. What are some of the methods of treating a deep facial infection?

A. Well, the first thing is to identify it and then to drain it, take away the offending source, if there is a foreign body, if there is a dead fragment of bone, if there

is an abscess that has to be removed surgically, that's number one, if that's present.

Number two is antibiotics and they are close in terms of effectiveness of treatment, they both are essential but antibiotics are a must as well.

Q. What kind of antibiotics would be recommended?

A. It depends on the type of infection, if it's a, just to give you an example, gram positive cocci, you would use a certain class of antibiotics, if it was a gram negative rods, say, which means that the digestive system may be implicated, you might use another class of antibiotics, so the decision about which antibiotic would he based on what you think the organism is or what the most likely organism is.

Q. What about staphylococcus?

A. That's one that would be treated with antibiotics for certain.

Q. What; kind of antibiotics?

A. Those that are good against gram positive cocci, whatever such antibiotics might

be at the time.

Q. Doctor, how did you become involved in this case?

A. I was asked to look at some medi records.

Q. Who contacted you?

A. Mr. Meador.

Q. Have you ever worked with Mr. Meador before?

A. I have not.

Q. Have you ever worked with anyone in Mr. Meador's firm before?

A. I have.

Q. And who is that?

A. Mr. Albert.

Q. Steve Albert?

A. Right.

Q. How frequently have you worked with Mr. Albert?

A. Well, it's not frequent, I would say two or three times maybe is the number of times I've worked with him.

Q. Anyone else at that firm?

A. Not that I'm aware of.

Q. When was the last time you worked

with Mr. Albert?

A. I would guess six, 12 months ago, something of that nature, not recently.

Q. Was that a medical malpractice case as well?

A. It was a medical malpractice case, -- yes, it was.

Q. Was your deposition taken in that case?

A. Yes.

Q. Do you remember the name of the plaintiff or the defendant?

A. The plaintiff in that case is a gentleman named Valach, V A L A C H, I believe, and the defendant physician was named Copola. The dates on this, I know it's within the past 12 months but I can't tell you for sure when.

Q. Ball park is fine at least with respect to dates. Do you know Dr. Chepla?

A. I do not know him.

Q. Do you know an oral surgeon by the name of Patrick Metro?

A. I do not know him.

Q. Do you know Dr. Devereaux?

A. I do know him.

Q. How do you know Dr. Devereaux?

A. I see him at meetings and in town and we both go to conferences, I've seen patients in common with him, I have referred patients to him over the years and we see each other casually and talk on a sort of a colleagial basis.

Q. Do you have an opinion as to Dr. [redacted] as a neurologist?

A. I do.

Q. What is that?

A. He's a good neurologist.

Q. And do you know Dr. Cole'?

A. I do.

Q. And how do you know him?

A. I know Dr. Cole two ways, I've known him since I've been in Cleveland, not as well as I know Dr. Devereaux, even though I don't know him that; well, my contact with Dr. Cole has been a little bit more distant but I also knew Dr. Cole when I was in training at Bowman Gray in Winston-Salem, he was a staff member there where I knew him in 1971 and 1970.

Q. Who is your medical malpractice

insurer?

A. PIE.

Q. Now, you've mentioned that you worked with Mr. Albert on a couple of occasions. Have you served as an expert witness or consultant on medical malpractice cases other than the two times that you've already mentioned with Mr. Albert?

A. Yes.

Q. How many times?

A. I would guess another two or three times, something of that nature.

Q. Four to six times total?

A. Yes.

Q. Roughly?

A. That's a rough estimate, yes.

Q. And have you ever been retained by the plaintiff in such a case?

A. In a medical malpractice?

Q. Yes.

A. No, I've not ever been retained by a plaintiff.

Q. Have you ever testified in court in any of the cases that you were retained as an expert medical malpractice witness?

A. I have not testified in court in medical malpractice matters.

Q. Have you testified in court in other matters?

A. I have.

Q. What type of cases were those?

A. Personal injury, degree of disability or cause of a problem relating to an injury is the usual situation.

Q. Have you ever testified on behalf of a plaintiff in those kind of cases?

A. I have.

Q. What percent would you say you testify on behalf of plaintiffs in personal injury eases?

A. Oh, it's a small. percentage, around 10 I would say is the number of times, 10 percent.

Q. How many times would you say you' testified in court in personal injury cases?

A. Ever?

Q. Yes, ball park.

A. I've been in Cleveland for 15 years and so if it's once or twice a year, maybe 20, 30 times, something of that nature.

Q. That's actual court appearances?

A. Yes, this is in a case that goes tu trial and so forth, yes.

Q. Now, the cases that you've mentioned relating to medical malpractice, have you had your deposition taken in those eases other than the one that; you mentioned with Mr. A 1bert?

A. Yes·

Q. How many times?

a. I would say two or three times.

Q. Was the occasion with Mr. Albert the last time?

A. Yes.

Q. And you're being paid for your services in this case?

A. I am.

Q. And what is your hourly rate?

A. $300.

Q. Now, have you brought with you your file in this case?

A. I have.

Q. And may I see that?

A. Yes. Here is part of it and here is the other part (indicating).

Q. Thank you. I think the major portion of this file is the Hillcrest Hospital records and the deposition transcripts of Dr. Chepla, Kathleen Nabozny and Dr. Williams; is that correct?

A. Right.

Q. Doctor, if you wouldn't mind to briefly yo through your file here and just identify, there is a letter to you from Mr. Meador dated March 30th, 1989 arid Dr. Metro's report; dated September 28th, 1987?

A. correct.

Q. Another letter from Mr. Meador which transmits various aspects of your file dated January 4th, 1989?

A. Correct.

Q. Dr. Williams' report?

A. Correct.

Q. Dr. Devereaux' report?

A. Yes.

Q. The office notes of Dr. Cole?

A. Yes, that's correct.

Q. The Hillcrest Hospital discharge summary for Kathleen Nabozny signed by Dr. Cole?

A. I think it's an amalgam of things including the hospital records, Dr. Chepla's notes, office notes and Dr. Cole's report, it's probably a compilation of sources, there is no single source.

Q. And referring your attention to the handwritten notes that we have marked as Plaintiff's MANN Exhibit Number 3, if we could do the same thing for those.

A. Sure. The first line is 7-8-86, extraction-Chepla.

7-10, hard to open mouth and pain, open parens, Rusch, meaning that's the source of that piece of information.

7-12, right temporomandibular pain, I've written Cole on the right side of that.

7-15 OV, meaning office visit, pain right ear and then the notation Chepla, meaning that she was seeing him then on the 15th and the 15th is written in there.

7-18 is numb in the right: cheek, parens Cole close parens, tender right face and I've put in parens Dr. Chepla's name and still under 7-18 office visit, edema of the right face, Keflex, meaning Keflex was started and

office visit probably unplanned.

7-22-86, under that, right tongue numb, right lower lip, right Roman Numeral V, which means the fifth finger and fourth finger are numb, right toes and then I've written no trismus and in parens Cole, the source of that information.

[illegible] office visit, pain in the right ear, numbness in the chin.

7-24, CT scan negative, slight right seventh nerve weakness.

7-25, abnormal gallium scan, petrosis, MRI abnormal.

7-26, I and D transorally by Rusch, Clindomycin started on the evening of the 25th.

7-28, Vancomycin, Gentamycin.

8-13, catheter for antibiotics.

8-14, antrotomy, Rederman.

9-14, discharge PO Clindomycin.

10-15, numb right corner of the mouth and right tongue.

Q. And on the back of Exhibit 3?

A. These are just scratchings, how quickly to RX, did delay, another entry, no in

hospital RX with antibiotics, and then the last entry is no way he could have known which antibiotic or infection at all.

Q. Tlie first note, how quickly RX, what does that mean?

A. That's an abbreviation, how quickly to treat.

Q. Do you know what you meant by that?

A. Well., yes, one of the things that comes up is how quickly can you treat this and how quickly do you know what it is, so I was thinking that was one of the issues I should try to decide something about when I was looking at this material.

o The copy of Dr. Devereaux' report that's contained in your file I believe has highlighting, it's a copy of a highlighted report of Dr. Devereaux'. Was the highlighting that is done in that report. done by you?

No, this must have come to me in this fashion, so I didn't highlight this, no.

MR. DeDANTIS: Off the record.

(Discussion off the record.)

MR. DeDANTIS: Mark this, please.

- - - - -

(Thereupon, PIaintiff's MANN Deposition Exhibit 4 was mark'd u for purposes of identification.)

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Q. I think we've identified everything that you've shown me that was contained in your file. Did you review anything else that is not contained in this file in order to prepare your report in this case?

A. Yes, I looked up as much material as I could in the literature on pterygopalatine fossa abscesses in the neurology literature.

Q. What sources would you have referred *to?*

A. Well, *in* neurology, I used my own textbooks, which are sitting over there on the shelf (indicating) and to a certain extent the journals that are there and for neurosurgery I used the hospital. library and Yoeman's is one of the standard texts of neurosurgery.

Q. How do you spell that?

A, Y *O* E M A N S, it's a five volume series.

Q. And it's titled Neurology?

A. That's neurosurgery but the neurology literature I used was, if you want to list it) --

Q. Please.

A. -- Clinical Neurology by Baker Baker·, some of them have been lent out), Diseases Of The Brain by Walton, Clinical Neuro-Opthalmology by Walsh, arid The Human Anatomy, Anatomy Of The Face by Morris, those are the texts I used here.

Q. Did you also mention that you referred to periodicals?

A. Yes, the journal. called Neurology, that's the green journal sitting on the two shelves, deep blue journal above it, which is called Annals of Neurology, and then the white one which is behind you called Archives of Neurology, those are the three major and then above that there is also in white the Journal of Neurosurgery.

Q. Were there any particular articles in any of those periodicals that was particularly on point.?

A. Well, the point there is that I couldn't find anything, I mean it's not indexed

in the past three or four years and I found nothing in those journals, now, maybe I didn't look hard enough, but doing an index search using that code for those journals, I was unable to find anything.

Q. On what subject?

A. Pterygopalatine abscess.

Q. And what about in the textbooks?

A. Nothing,

Q. And how about at the library?

A. Nothing. The search wasn't exhaustive but I consulted one of the texts of neurosurgery and the Journal of Neurosurgery, so it's not a subject you find easily in those sources.

Q. So did you find any articles or any literature on pterygopalatine fossa infections or abscesses?

A. I did not.

Q. Did you review or rely on anything else in the course of your examination of the records in formation of opinions in this case?

A There is one other article I looked at sitting in my file somewhere.

Q. Would that be the one that was

attached to Dr. Metro's report?

A. Yes, yes, the Dr. Metro article and the anatomic review he did are what I relied on in making my opinion.

Q. I've marked I believe what is your report as Plaintiff's MANN Exhibit. Number 4, if you could verify that that is a copy of your report.

A. It is.

Q. And that report contains your opinions about this case?

A. It does.

Q. Does that report: contain all of your opinions relating to this case?

A. Well, all the opinions I have? It's the bulk and most of the opinions I have but there may be opinions that are relevant that didn't surface in here but that's my basic feeling about this case.

Q. Are there any opinions that you can think of offhand that you have about this case that are not contained in your report?

A. None offhand. I mean this doesn't represent every thought I've had about this case.

Q. I understand.

A. Rut most --

Q. Let me put it to you this way, maybe it would be easier. Are there any opinions which you have that you have discussed that may be asked of you at the trial of this case that are not contained in this report?

MR. MEADOR: Well, the only reason why I would object: to that, Frank, is I don't know he knows what questions I may ask him on which he would have to render an opinion.

MR. DeDANTIS: I understand that but what I'm asking him is is he aware: of any opinions that he knows are going to be advanced at this trial that are not contained in that report, I mean obviously he can't predict what you haven't told him or what you haven't discussed with him, I'm only asking him those that he is aware of.

A. Ani I aware of other opinions that I might advance that aren't mentioned somehow in here? No.

Q. That's fine. You've got it. Now, in the first paragraph of your report, I'm going to refer it to as your report as opposed

to Exhibit 4, you list the various things that you refer to in compiling your report.

Let me ask you this first. Is there anything that isn't listed here that you've looked at since preparing this report?

A. Maybe casually, I mean I may have looked when I was in libraries at other things but there has been no concerted major effort to bring new information to bear on this case since February 22nd other than what I might do casually or think about: casually or ask about casually.

Q. Have you seen Dr. Devereaux' deposition transcript?

A. I've not.

Q. Have you talked about Dr. Devereaux' deposition with Mr. Meador?

A. I have.

Q. And did he give you any facts about what occurred at that deposition?

A. He did.

Q. And what facts were those?

A. That Dr. Devereaux, if I have it right:, suggested that Mrs. Nabozny may have been treated earlier and gotten a better

result.

Q. Anything else that you can recall?

A. Not offhand now.

Q. Have you talked with anyone else about the case or the subject matter of the case since you prepared your report?

A. Possibly Mr. Meador but nobody else.

Q. Now, referring to the first paragraph on the list of items that we've already discussed from your. file, particularly number one, the office notes of William Chepla, D.D.S., do you consider anything contained in those office notes to be of significance to you in preparing your report or coming to the conclusions that you arrived at that are contained in your report?

A. I do.

Q. And what would those be?

A. Well, looking at the notes themselves, namely he's writLen down what he did, the date of the extraction, which things he took out, and then his seeing her on subsequent days and the types of complaints she had and what. he did, so there was a Lot of

material I used in his office notes.

Q. And how about the office records of Dr. Cole, the same question, was there anything contained in those records which you felt to be significant to the conclusions that you ultimately arrived at?

A. Yes.

Q. What would those be?

A. Well, the way she looked to him when he first saw her, the findings that are written down in his office notes, so her clinical presentation on the 23rd of July, what kind of complaints she had, what kind of pains she had were important to me and also what she told him, so those were also important.

Q. You did not read the deposition of Dr. Cole; is that correct;?

A. No, I haven't seen his deposition, I didn't know he'd been deposed actually.

Q. Was there anything contained in the report of Dr. Devereaux that you felt to be significant in formulating your opinions?

A. His report was a rehashing of some primary detail I had like the hospital. record, what Dr. Cole saw and so forth, so it was

important seeing this material extracted or abstracted but it was repetitious in the sense of what was there was also available in other documents.

He also examined her and that was helpful in my report.

Q. In what sense?

A. Well, he did a physical examination, he checked hex sensation.

Q I understand what his exam was but in what sense did it. help you in your report.?

A Seeing what kind of problems she still had, where her numbness was, what kind of paralysis she had, that sort of thing, how bad it was.

Q Anything else about Dr. Devereaux' report of any significance to you?

A Offhand, *not* that I can say specifically.

Q. What about the Hillcrest Hospital records, is there anything contained in those records that was of significance to you in formulating your- opinions?

A. Yes.

Q. And what would that be?

A. Well, practically the whole record, the difficulty of the diagnosis the first 24, 48 hours she was there, the trouble they were having establishing what was wrong when everybody knew something was wrong, the extent to which they had to go to prove this with basically a scan, the complexity of the treatment, the development of additional treatment measures, the antibiotic, the need to open up the maxillary sinus, all. were factors that were necessary to treat this condition and keep her there for six or eight weeks, so practically everything that happened in the hospitalization had some bearing on her condition in my report.

Q. Now, you mentioned the extent to which they had to go to diagnose her problem. What do you mean by that?

A. When she first got into the hospital it wasn't clear what was wrong, there were several areas of suspicion, particularly the face, but nobody knew exactly where or what the next thing to do was to treat it.

Q. How did they ultimately diagnose her'?

A. In my understanding, it was the gallium scan that finally showed a hot spot in the face and I can look that up if you want me to tell you specifically when that was done but that was the first thing that showed them where the problem was and the MRT scan showed it to them and then that led to surgery on the 26th or whenever she had the procedure.

Q. Was there anything in the deposition of Dr. Cheyla that you felt was significant in arriving at your opinions, deposition transcript?

A. Well, he detailed what symptoms Mrs. Nabozny had and how he treated them and that confirmed what he said in his notes and made a stronger impression on what kind of clinical material he was using when he treated her.

Q. Anything else?

A. I don't recall anything offhand without looking up the whole transcript, subject by subject.

Q. How about the deposition transcript of Dr. Williams, was there anything contained in that transcript that you felt was

significant to you in arriving at your opinion?

A. No.

Q. And what about the deposition transcript of Mrs. Nabozny, was there anythi of any significance to you in formulating you opinions in that transcript?

A. It was helpful to see what her symptoms were as she related them firsthand and so that was helpful but there was nothing, I can't say there was something specifically there that made me say *yes or* no about a certain issue.

Q. And was there anything of any significance *to* you in the report of Dr. Williams formulating your opinions?

A. No.

Q. How about the report of Dr. Metro, was there anything of significance in that report?

A. Yes.

Q. What was that?

A. Well, Dr. Metro, a dentist -- let me just. look at his notes.

Q. Please.

A. -- another dentist, talks about the unusual characteristic of the abscess, I mean I thought it was very unusual, I mean he does too, the issue of pain, the use of antibiotics, these are things I don't do for this and so that was helpful in giving me an idea what; a dentist would do under these, another dentist would do under these circumstances, so it was helpful in khat; way.

Q. May I look at that report, please?

A. Yes.

Q. What portion of that report talks about pain?

A. Well, it doesn't say pain specifically but he's talking about what Dr. Chepla does, that what he did was okay, and and I extend that to the pain and seeing her after she has had her extraction, taking sutures out and that type of thing, and the fact that that: kind of infection is rare or difficult to diagnose, to use his words.

Q. So that Dr. Metro's opinions about the way Dr. Chepla conducted himself was of significance to you in formulating your opinion?

A. It was of significance to me in looking at it from the dental standpoint from another dentist and was helpful in my opinions in that sense, yes.

Q. Why was that report of significance to you and Dr. Williams' report not of significance to you?

A. Dr. Williams' report says that he has only seen this once in a very great while and I can't remember the exact number of figures and then goes on to talk about it at length like it were an everyday thing, to me there is an inconsistency there.

Q. And as a result of that inconsistency, you disregarded his opinions?

A. Well, he didn't bring anything to light in my mind that would help me understand this case any further.

Q. Now, in the second paragraph of your report, page 1, you mention that Mrs. Nabozny had a routine extraction on July 8th.

A. Yes.

Q. What did you mean by routine extraction?

A. That she went in and had the

extraction and went; home without any apparent trouble.

Q. In your recitation of the facts in this paragraph, you did not mention that Mrs. Nabozny experienced increased pain or a difficulty in opening her mouth two or three days after surgery but as we mentioned you do note that: in some of the handwritten notes you have in your- file.

Is there any reason why you don't. mention that fact in your recitation of the facts in your report?

MR. MEADOR: Well, I'm going to object. inasmuch as you're stating it as a fact. You understand that that's an issue of fact in this case.

MR. DeDANTIS: I wasn't asking him if it was a fact. I was just asking him why he doesn't have it in this report although he has it in his notes.

MR. MEADOR: Right, but your question assumes that those are facts in this case and what I'm saying is that I'm objecting to those --

MR. DeDANTIS: My question doesn't

assume that those are facts. What I've stated is that there are notes in his handwritten notes about that subject and there are no notes in this report and I just asked him if there was any reason for that.

Q. Doctor, are you waiting for Mr. Meador to comment or are you thinking about the answer?

MR. MEADOR: I don't have any other comments, so don't wait for me.

A. The comments about hard 'to open her mouth I believe came from the hospital records and I couldn't. tell, that was secondhand information, so I just stuck with the things that I could determine at least from Dr. Chepla's records, a patient in the hospital telling the doctor something doesn't seem to have the same status, he didn't write anything about it and I thought he would have, so I just didn't mention it, I'm not taking a particular notion that they are not hut unless it's in his notes, I mean it seems to me like that's something he would write down if it were there, so I just; didn't include it;.

a. And you read Mrs. Nabozny's

deposition transcript?

A. I have, yes.

Q. And did she not testify that she experienced difficulty in opening her mouth and pain two or three days after the operation?

A. I'd have to look at the specific place. I did read it and I think she did but I'm not positive and so I have to look at the deposition and find that but if you tell me she did and it's there, then, yes, and if I did look at it and find it, then I could believe khat she did say that..

Q. In your opinion, is an increased pain and a difficulty in opening the mouth of any significance to your opinions in khat case?

A. After dental extraction, I don't think they are particularly significant, no.

Q. So that if in fact Mrs. Nabozny did experience a difficulty in opening her mouth two days after surgery or three days after surgery or four days after surgery, that would have no bearing on your opinion in this case?

A. It would depend a little also on how difficult and how prominent a symptom it

were, I would expect someone with a large number of extractions would have trouble using their mouth for a lot of activities, .iE she couldn't open it at all, that wou1d be significant, if she could open it but it was uncomfortable, that's another kind of significance, if she couldn't open it all the way to blow bubbles or something, that's not so significant, so it depends on the quality of the report about opening her mouth.

Q. Where in that continuum that you've just. described, if anywhere, would your opinions change if the facts lined up?

A. What would bother me about opening your mouth in that couple days after the extraction?

If a patient had inability to open the mouth at all, couldn't get the teeth apart and the condition you see in severe nerve impairment and diphtheria, for instance, that's significant.

Q. And if that situation occurred seven days after surgery, would that concern you?

A. Couldn't open the mouth at. all to

eat or talk, yes.

Q. Extreme pain in opening the mouth, even slightly?

A. To move the mouth at all and by extension unable to eat and talk properly, yes, that would alarm me.

Q. Later on in this same paragraph that we're referring to you mentioned that numbness is the first appearance of the specific symptom which may have a neurological basis, and I'm paraphrasing.

A. Yes.

Q. Could the difficulty in opening the mouth to the extent that we've just described have a neurological basis?

A. It could, yes.

Q. Is it your opinion that Dr. Cheyla should not have taken any action or any further action than he took until there was a symptom of neurological basis?

A. Generally, yes, I don't think anybody taking care of this patient can take any action until they think there is something wrong and that means finding something specific, and in this case a neurologic symptom, I mean

there could be others, bleeding, et cetera, fever, but I don't see him finding anything wrong with her until the 22nd, 231d or 24th of July when other things started to happen.

Q. Are you rendering an opinion in this case as to the care and treatment of Mrs. Nabozriy by Dr. Chepla?

A. Yes, I'm rendering an opinion about when one should think of neurologic types of problems and by extension his care of her since he was in charge of the case at that time.

Q. And when you say one, are you referring to anyone in the world or oral surgeons or neurologists or who?

A. Well, I think it would encompass that amalgamated group of people who take care of patients with oral or facial problems, so I think those kinds of symptoms I'm talking about should be evident to neurologists, dental surgeons, other people who work around the face, internists if the case arises, et cetera, so I think when you get something concrete neurological, then I think people who work in that area should recognize it and do something about it, whatever- that: means, it means one

thing for a dentist and another for a neurologist and the neurosurgeon.

Q. But you're focusing in on neuro1ogica1 problems?

A. I am.

Q. What about other symptoms that may occur post oral surgery?

A. Well, if they are strictly oral. surgical, like sutures falling out; or bleeding from the gums or something like that., then oral. surgeons know more than neurologistu, so there are some symptoms and some conditions that arise in these situations that I think neurologists probably don't know very much about and there are other symptoms that neurologists know lots about and then there is an overlay zone, this so-called area that we're getting into now.

Q. And I presume khat you haven't done any oral surgery yourself?

A. Me? No, I have never done oral surgery.

Q. Dental extractions?

A. No, I've only been the subject of that sort of treatment.

Q. And have you treated anyone directly postoperatively to a dental extraction?

A. Right away after a dental extraction, I have not.

Q. And therefore, I presume you're not familiar with the symptoms or condition of a patient directly after a multiple extraction oral surgery?

A. Well, I am to the extent that I've had it described to me by any number of patients who later tell me about things such as headaches or myself or other people like family members who get such treatment, so I have some familiarity with it, not on a high level of experience.

Q. Not direct experience?

A. Not direct rendering of care, no.

Q. Now, paragraph three, still on page 1, doctor, you indicate that Mrs. Nabozny apparently had no difficulty opening her mouth, referring to Dr. Cole's evaluation of her.

A. Right.

Q. What is the basis of that statement?

A. Well, I didn't see any notation in his office note about her having trouble opening her mouth, I mean he detailed a lot of other things and he looked in there, so at that point she could open her mouth, I think.

Q. Would any of the opinions that you've rendered in this report change if in fact Dr. Cole had noted a pain or had noted that Mrs. Nabozriy experienced pain or had difficulty in opening her mouth at the time he examined her?

A. Well, again, it depends on the level of pain and the difficulty with opening the mouth, so if she has excruciating and severe pain arid can't open her mouth and he can't even look in, yes, that's serious.

If she has discomfort when she opens her mouth all the way, and I suspect she must have by then, that doesn't surprise me, knowing what's going on here at that point, so it's a question of the quantity of pain.

Q. Well, let's take the far end of that continuum, again, if in fact Dr. Cole had noted excruciating pain by Mrs. Nabozriy in attempting to open her niouth, how would that

change your opinion?

A. Well, that adds to the symptoms she already has because she already has numbness and findings in her face, so that's one more, I mean by this time you're already talking about neurologic involvement, neurologic impairment, neurologic findings, so opening her mouth being difficult would add to the number of symptoms and findings she had on the 23rd when he saw her.

Q. Are you familiar with the term trismus?

A. I am.

Q. What is trismus?

A. That means inability to open the mouth but due to muscular contraction, usually involuntary, of the muscles that close the mouth.

Q. In the last sentence of that third paragraph you're referencing a perplexing numbness in the right fourth and fifth fingers and right fourth and fifth toes. In your opinion, could the abscess that Mrs. Nabozriy had have in any way caused that problem?

A. No, it's impossible, they are

different parts of the nervous system altogether.

Q. Now, on page 2, the second paragraph, you indicate that the earliest this condition could have been diagnosed would be after the 18th of July, sometime after the 18th of July; is that correct?

A. In my opinion, yes.

Q. And what is the basis of that opinion?

A. Well, up until. the 18th *there is*, and even after the 18th, there is nothing hard to yo on here, she just. has some pain and this all looks like pretty much a standard sort of thing from lots of dental extractions, so I don't think anybody can say there is anything wrong with that, I mean Dr. Chepla *is* there, he's seen hex. three times, he's on sight looking at her, you can learn a lot more about pain from seeing people than you can from hearing about it, I mean pain is a physically facial demonstrative emotion even more so than it is something you talk about., so he is looking at her all this time and doesn't see anything, so I don't see how he possibly could

have thought there was something wrong before the 18th and probably not afterwards either.

Q. Now, let me see if I understand. Are you saying from the symptoms as you understand they were being exhibited by Mrs. Nabozny the diagnosis could not have been made by the oral surgeon seeing her until sometime after the 18th?

A. Right, the symptoms that he is seeing and treating, right, cannot be diagnosed or treated any time before the 18th.

Q. As you understand those symptoms?

A. Yes.

Q. Now, let me ask you this. You're not saying that had the tests that were ultimately performed on Mrs. Nabozriy at Hillcrest Hospital been performed on her the 16th or the 15th or the 17th, a diagnosis could not have been made of the pterygopalatine fossa infection at that time, are you?

A. If she had had those tests earlier -- what was the conclusion, that they couldn't diagnose it?

Q. I'm asking you, are you saying, this is kind of a broad sweeping statement and

I'm just: trying to isolate exactly what you're saying by it. and I guess I gave you a negative question but you're not saying that: had those tests been done earlier than the 18th a diagnosis could not have been made?

A. I am not saying that but I can tell you about that if you want to hear my opinion about that.

Q. Please.

A. The earlier you do those tests, the less likely they are to be abnormal, one is a metabolic test that relies on turnover of tissue so that you're looking for things, basically infections, and if the infection is a cold one or not heated up and you do it: too early, you miss the case, sa we didn't do those tests on the 18th so we don't know what they showed, and maybe they would have been abnormal but there is less likelihood of that on the 18th than on the 24th or the 23rd when they were done for sure.

Q. But is that a reason not to do them if you suspect that: something is amiss?

A. The lesser likelihood is not a reason not to do them if you follow me.

Q. Yes, I do. Let me just follow that up. If Mrs. Nabozny had a pterygopalatine fossa infection abscess on the 17th or the 16th or the 15th and an MRI and/or the gallium scan had been performed, could that infection have been diagnosed at that time?

A. I would guess not. I would say not at that early date.

Q. And what's the basis of your opinion?

A. Well, she is still looking pretty much like a straight forward dental extraction, post dental pain kind of patient. I don't think that the infection part of this enters the picture until later, so I think if she has the tests they are too early to catch the condition.

Q. Let me add some facts then in a quasi hypothetical manner.

Would what if on the 15th she was experiencing extreme trismus and the pterygopalatine infection was in place, the abscess was in place at that time, would the MRI and gallium scan have been able to give you a diagnosis or been able to give you the

ability to make a diagnosis at that time?

MR. MEADOR: I'm just going to object to those facts.

MR. DeDANTIS: I understand.

A. Looking at the second part of it, if the abscess were there and assuming it's the right side, which if it's there it's the right side, they should have picked it up on any date, yes, the 15th, the 14th, yes, on any date.

Q. Well, then let me ask this question. Now I'm confused. Let me *go* back then. It's my ignorance so let me just make it clear, I don't want to belabor it: but I want to make sure I understand.

If Mrs. Nabozny were given the MRI and gallium scan tests on the 15th, 16th and 17th and the pterygopalatine fossa abscess was there at that time, then a diagnosis could have been made at that time, is that what you're saying?

A. Yes, if the abscess is there, most modalities, particularly the gallium scan, should be abnormal and that leads to the diagnosis or the surgery or whatever later.

Q. And your answer to the question that I asked you that was similar to that earlier was that you don't believe in this case it would have shown a pterygopalatine fossa infection because it was too early on and the basis for that opinion was that from the symptoms as you understand them the infection wasn't at a stage where it would have been able to have been diagnosed; is that accurate?

A. Right, in a word, I don't think she had the abscess before then.

Q. And now let's go back to the question that I just asked you three questions ago.

If Mrs. Nabozriy were experiencing extreme trismus on the 15th, what is your opinion with respect to the MRI and gallium scan at that time or do you have an opinion?

MR. MEADOR: Objection.

A. Yes, I have an opinion.

Q. What is the opinion?

A. Still would have been normal.

Q. What is the basis of that opinion?

A. Well, trismus for a day or trismus for hours doesn't mean, doesn't translate into

the presence of an infection.

Q. Now, let me ask you this. If Mrs. Nabozny were experiencing extreme trismus on the 15th and then on the 18th, we're talking about July of 1986, she began to experience a numbness in her face, do you have an opinion about: whether a galliuni scan and MRI would have been able to give you the ability to niake a diagnosis of the pterygopalatine fossa infection at that time?

A. On the 18th?

MR. MEADOR: On the 18th?

MR. DeDANTIS: Yes. It would have to be on the 18th.

A. Well, I still think the scan would have been negative at that early date.

Q. And why is that?

A. Well, again, there is not enough quantity of symptoms, she only has difficulty opening her niouth which can be due to other things, you're talking about events on a single day arid then nunibness later, perhaps explained by other things, so the quantity of symptoms and the quality of the symptoms are not enough to me to suggest that there is an underlying

abscess at: that: time and hence, if there is not: an underlying abscess, I don't think the scans will show it.

Q. What further information did Dr. Cole have that would have caused him to recommend the MRI and gallium scan?

A. Well, she then has weakness of the face and findings of loss of: sensation in the face and those are pretty reproducible or the loss of sensation and I think that keys in to him that; there is a nerve impairment or a nerve blocked or a nerve not working, it's not just a case of a pain or maybe numbness, it's a case of a nerve injury, paralysis, however you want to think of it.

Q. Is there a distinction between numbness and a loss of sensation?

A. Oh, yes.

Q. What would that distinction be?

A. Well, the loss of sensation is a technical term that neurologists use and it has many clinical manifestations, numbness being one of them, crawly creepies, dead feelings, novocaine like feelings and so forth are basically the types of symptoms that patients

or lay people use, so numbness is a lay term, it means a broad number of things to patients.

Loss of sensation is a very specific, detailed term that neurologists use meaning there is something wrong with the nervous system to account for a certain location of something being wrong, it happens to be in the sensory system.

Q. Do you have any basis for concluding that the numbness that Mrs. Nabozny complained about on the 18th was any different than the loss of sensation that Dr. Cole identified when he examined her?

MR. MEADOR: I'm going to object to your statement that indicates numbness was found on July 18th since that's one of the issues of fact in this case.

Q. Subject to that objection, doctor?

A. Was there a difference between Dr. Chepla's numbness on the 18th and Dr. Cole's numbness findings on the 22nd, 23rd?

Q. Yes.

A. Yes, I think so.

MR. MEADOR: Well., I don't know if you got that right. You say Dr. Chepla's

numbness on the 18th. That's not what the question was.

The question was numbness versus loss of sensation and Frank was assuming there was numbness on the 15th and Dr. Cole, we know, found the loss of sensation on the 23rd.

MR. DeDANTIS: Well, I didn't: say the 15th. I said the 18th.

MR. MEADOR: The 18th. No, you said the 15th the first time. Oh, you may have said the 18th. Either way, there is no finding of nunibness on Dr. Chepla's notes on the 18th or the 15th. You did say the 18th.

Q. Why don't we do this. I think it will be easier if I withdraw that question and ask you another one.

Let's go back to my hypothetical. If Mrs. Nabozriy had been experiencing extreme trismus on the 15th and a loss of sensation in her cheek on the 18th, a loss of sensation as you define that, what would be your opinion about the potential results of an MRI and gallium scan at that: time vis-a-vis the pterygopalatine fossa abscess that Mrs. Nabozriy was u1timately di.agnosed as having?

MR. MEADOR: Same objection.

A. A scan being done on the 18111 --

Q. Yes.

A. -- I believe would be negative.

Q. What's the basis for your opinion?

A. Because she has a symptom which isn't that significant a symptom, trismus, on a single day.

Q. Well, okay, I didn't mean she had it and the211 it went away. I meant that she had severe trismus on the 15th and continued to have that: severe trismus and in addition to that began to manifest the loss oE sensation i.n her face. I didn't mean to imply that the trismus was only that day. Let. me hack up.

A. Yes.

Q. Let me withdraw that question and ask you another question.

What about had Mrs. Nabozny began experiencing trismus two days after surgery, which continued to increase and became extreme on the 15th and continued until the 18th when she also began manifesting a loss of sensation in her cheek, subject: to Mr. Meador's continuing objection on the facts, do *you* liave

an opinion with respect to what; the gallium scan and MRX results would have indicated?

A. I do.

Q. And what is that opinion?

A. I believe they would have been negative on the 18th.

Q. And what is the basis of that opinion?

A. Well, the hard clinical facts from the practitioner seeing her are khat she can move her niouth a certain way, I mean he looks in there, he looks at her, she doesn't look that sick to have a facial abscess or even a nerve impairment on the 18th, so I just don't think there is enough clinical level of syniptonis to assume that there is an abscess cooking and that a scan that will. show that.

Q. And the basis of your opinion essentially is Dr. Chepla's observations and notes with respect to her condition on the 18th?

A. His impression, yes.

Q. Let me ask you this question, doctor. What if Mrs. Nabozny's symptoms were identical on the 18th to those that she

exhibited on the 23rd when Dr. Cole examined her, do you have an opinion of the possible results of the MRI and gallium scan had it been done on the 18th?

A. If she were the person on the 23rd that she was on the 18th, I think the scan would have been positive, yes.

Q. Directing your attention to the third paragraph on page 2, when you say index of suspicion to anything being amiss, are you talking about from the standpoint of a neurologist or from the standpoint of an oral surgeon?

A. I think largely from the, there being something wrong neurologically which neurologists would be quick to pick up on but I think oral surgeons would be too, so it's a neurologic thing but I think oral surgeons would be aware of that also but as far as we're concerned, neurologists, when somebody loses sensation and has abnormal findings, then that means something is going wrong.

Q. Directing your attention to the fourth paragraph on page 2, you state that Dr. Chepla could not have had a heightened

awareness of a peripheral nerve compromise or an abscess until around the 22nd or 23rd or 24th of July, correct?

A. Right..

Q. You're not saying, are you, that there were not; sufficient symptoms to cause Dr. Chepla as an oral. surgeon to seek other tests tu determine Mrs. Nabozny's problems before the 22nd or 23rd or 24th, are you?

A. I am.

Q. At what point as an oral surgeon should Dr. Chepla have been attempting to identify Mrs. Nabozriy's problems?

A. I think as soon as there is something that generally speaking doesn't belong, like weakness, intense pain, sensory symptoms.

In this case, the 24th when she has weakness of the right face, well, that clearly is abnormal, that means something is wrong, so that definitely means other types of tests have to be brought into the picture.

Q. Now, are you focusing only on neurologic problems?

A. Yes.

Q. Now, if an oral surgeon performed multiple extractions on a patient and in the course of his postsurgical care identified symptoms that were unusual for the normal postsurgical progress of that; patient; and those unusual symptoms had no direct neurological connection, you're not rendering an opinion about what an oral surgeon should do at that point, are you?

A. I am not, no.

Q. So the focus of your opinion is that until an oral surgeon or anyone can identify a symptom as relating to a neurological problem, then that kind of a diagnosis can't be made?

A. Right, or the suspicion thereof can't lead to a sequence of events that yet a diagnosis made, yes.

Q. But you're not saying that as a neurologist you can testify or render an opinion about symptoms that are postsurgical to an oral surgery that may be unusual for that situation?

MR. MEADOR: Well, I'm going to object to the question. I think what you meant

to say at the very end was instead of saying in that situation what you probably were trying to get at was as to an oral surgeon, maybe that didn't clarify your question at all, but let me just object to it arid then you can ask it however. you want,

Q. Did you understand the question?

A. I think so, yes.

Q. Why don't. you answer it then.

A. Things that would be out of kilter for an oral surgeon and oral. surgeons say don't belong, I'm not that well versed in, if they say such and so shouldn't happen on day five, I take their word for it, I'm not an expert at how much bleeding, how much trouble with alignment and so forth of the jaw should take place on days five, six and seven of certain kinds of extractions, so I wouldn't be the person to ask about those specific surgical matters.

Q. And the reason Mrs. Nabozny's problem became neurological relates to where the abscess grew and what. nerves it touched; is that correct?

A. correct.

Q. The fact of an infection is not neurological in and of itself, is it?

A. It is not.

Q. And the fact of an infection, until that infection causes some damage to a nerve, it doesn't become a neurological problem?

A. Right, it's almost an accident that it hit nerves, it could have hit something else, the sinus, for instance, in which case you would never hear from a neurologist in this case.

Q. Now, let me follow up on that. This infection could have existed before it became a neurological problem?

A. Oh, it most likely was there before it manifested itself as a nerve compromise, yes.

Q. Are you rendering an opinion as to when Dr. Chepla should have identified that this infection existed?

A. Well, indirectly by the manifestations it took, yes.

Q. Well, let me ask you this. Are you saying that: this particular infection can only be diagnosed after it has become a neurological

problem?

A. No, but that's probably the most likely way, because the nerves are the most sensitive structures, you could have this infection with sparing of the nerves, I suppose, and muscle involvement and just have facial pain of an excruciating type or it could break into the sinus and then you'd get a terrible sinus condition, so the neurology of this is just sort of how the cards fell.

Q. Do you know whether trismus could be a symptom of pterygopalatine fossa infection?

A. It could be.

Q. Could it have been a symptom of that disorder prior to it becoming a neurological disorder?

A. I think that's unlikely.

Q. Why?

A. Well, if you've got an infection in your face, and this is a fairly active infection, it's not an indolent one, and it's growing, okay, it's already isolated from the blood stream and it's got a life of its own and it's already under way, those things don't come

and go, once they are there they sort of let their presence be known by continuing and progressive and increasing symptoms, so you don't get sort of better one day from an abscess and then worse the next and then better the next, there is sort of a steady progression of syniptonis, so I think at the point that there is significant symptoms and progression, then we know we're talking about destructive processes and that's why I think you just can't. say the trismus on a given day meets an abscess, particularly when lots of other things cause trismus.

1 don't see the crescendo signs and syniptoms developing until later in Mrs. Nabozny.

Q. Sometime after the 18th?

A. Yes.

Q. Rased on the symptoms as you understand them in this case?

A. Correct, and Dr. Chepla's examinations, yes.

Q. In that. same paragraph you state that it is splitting hairs to assume that a few days could make a difference one way or another

in the outcome.

In your opinion, is there a defined amount of days that would have made a difference?

A. Well, is there a time segment at which you can tell it would have made a difference? Yes, I think there is such a thing. You can't say one day gets a better result than another or two or another. You can say that if you wait a month, I mean to treat such infection, that's inordinately long and that would beget a worse outcome with certainty.

Q. She possibly could have been dead in a month?

A. Well, yes, particularly if the infection went intercranial, into the brain.

Q. Anything less than a month?

A. Yes.

Q. And why don't you describe that.

A. Well, these are distinctions that don't exist in medicine and biology, I mean it's like deciding when night ends, there is no given moment, so I'm going to give you some rough ideas in my opinion when things started

to shake out not too good.

Q. Please.

A. I think that if you harbor an infection like this a couple of weeks, you know, 14 days, I think that's getting to be longish, if you harbor it a couple of days, it's hard to say that that makes any difference at all, it probably doesn't, so somewhere between, and this is arbitrary and just my opinion about the way infections work around the nervous system, be it in the nerves in the legs or the face, more than a couple of weeks and so on, depending on partial treatment, which may be a factor here, then you're starting to *see* permanent problems, particularly if you're certain *when* it's started, so if you can say yes a certain person has an infection say in the face or the knee around a nerve and it's not been suppressed by antibiotic treatment and so forth and it's gone on untreated that, yes, after a couple weeks they'll have trouble and it will be irreversible.

Q. So trying to put that definition into this fact pattern, you would expect; if

Mrs. Nabozny's condition went untreated for a couple weeks that she would have the kind of permanent problem she ended up with?

A. Without any treatment at all, yes, if she went I would say beyond 14 days from day one, whenever. that. is, without treatment, without adequate treatment, yes, I think that she would be in trouble in terms of having something that stuck with her afterwards.

Q. In fact, she did have a permanent problem?

A. Indeed she did.

Q. So that you would have expected treatment sometime 14 days before that to have an effect on preventing that?

A. If, using a sort of a crystal ball., she had been treated before then, I think that treatment. would have been, that would have taken her. treatment to the 14th, I think that would trave been a little outrageous to give her those kind of antibiotics on the 14th with the clinical material she had but, yes, if she had been given those things perhaps in thal time frame, yes, she might not have had a permanent numbness.

Q. And once again, you're saying that your two-week period is not a hard and fast rule, there is flexibility there, I would presume then that. the same may be true of the 15th or the 16th?

A. You're talking about the days or the two weeks?

Q. July 15th or 16th. You said that 14 days would have taken her back to like the 14th.

A. Well., actually, it would have taken her back to the 12th, 14 days from the 26th would take her back.

MR. MEADOR: 14 days from what? I think we've got to yet that. clarified.

A. The 26th when she first had antibiotics, the first definitive antibiotics.

MR. MEADOR: Oh, okay.

MR. DeDANTIS: Right.

Q. I understood what; you said but for some reason I was going from the 28th. You said the 14th and that seemed right; to me but you're right, it would have been the 26th and it would have been the 12th.

A. Right. Now, your question is what

happens if she would have been treated on the --

Q. Well, let. me start *over*. You said that it wasn't a hard and fast rule but your. rough guesstimate is somewhere in the 14 day . range and I'm saying, are you saying that: had she had that treatment on the 15th or the 16th, are you saying definitely it would not have had an effect on preventing the permanent damage that she had?

A. If, again, in this highly artificial world she had been treated on the 15th, I can't assert that she would have had no damage from that treatment, I don't know that anybody can, I just. don't think there is that much science in this and, again, I think it would have been unreasonable to do that at. that stage of the situation and I don't know how anyone can predict that if she had gotten antibiotics on the 15th or 16th or 17th or 18th that she would not have developed into this trouble, I don't think anybody can say it, can say yes or no, unless we do this little experiment we do not now what the outcome is. I can tell you what is long and short but there

is a big gray zone in there.

Q. And that's in the gray zone:?

A. Yes, it: is.

Q. Let me ask you this, if the abscess had been identified and treated before she started experiencing any paraesthesia or numbness in her cheek or anywhere in her face, do you have an opinion about whether. the permanent nunibness could have been avoided?

A. Well, the --

Q. Holding aside your views about when that treatment should have occurred ox when it would have been reasonable to occur.?

A. If we give her antibiotics before she has very specific: numbness and of pins and needles, neurologic type, *et* cetera, just medical judgment tells us that that's more likely to prevent. problems but I cannot assert that just treating her before that either 24 hours or 48 hours would have prevented the whole thing, it's more likely to have, the earlier you treat these things the more likely you are bo have a good result, but to say that if it. had been 24 hours before she had neurologic syniptonis that would have prevented

it, I think that's pushing it, other people may 'tell you that and maybe they know more about it than I do but I just; can't say that a given time frame before it would have prevented the whole problem unless you yo out a matter of days.

Q. Do you have an opinion as to whether Mrs. Nabozny has a permanent nunibness in her right chin, right side of the tongue and right side of the mouth?

A. I do.

Q. And what is that opinion?

A. She does.

Q. Do you have any opinion as to cause of this permanent numbness?

A. I do.

Q. What is that opinion?

A. The pterygopalatine abscess that she had in July of 1986.

Q. Do you have any opinion as to the cause of that infection?

A. I do.

Q. Arid what is that opinion?

A. I think it was related to the entry of organisms through the mouLh when she had the

dental extractions.

MR. DeDANTIS: Mark this, please.

- - - - -

(Thereupon, Plaintiff's MANN Deposition Exhibit 5 was mark'd for purposes of identification.)

- - - - -

Q. Directing your attention to what we've marked as Plainitff's Exhibit 5, which is Dr. Devereaux' report, are there any parts of that report to which you disagree?

A. I don't think there is anything within, just looking at it now, khat I would take major issue with. Dr. Devereaux quotes from Dr. Cole's notes as have I.

The question is of exactly what kind of numbness she had on the 18th and whether that was significant ox' not. I've talked about he paints the picture looking backwards of an increasing pattern using other sources, including the patient herself.

I may disagree with exactly what happened when but I don't disagree with his recording of this or his conclusions or basically what he says in his report.

Q. In the convex-sations that: you had with Mr. Meador about. Dr. Devereaux' deposition, was there anything in what he related to you about that deposition that you disagree with?

MR. MEADOR: What's the question?

MR. DeDANTIS: Let me make it more precise. It. wasn't a good question but I was hoping he would understand what I meant.

Q. In your conversations with Mr. Meador about: Dr. Devereaux' deposition, was that was related to you that you disagreed with?

A. You better cite the specific example of what: it was in my conversation with Mr. Meador that. I might have disagreed with about Dr. Devereaux' deposition.

Q. You want me *to?* I wasn't privy to the conversation. I really don't know what he told you. You mentioned earlier that there was, it: was relayed to you that he thought that: -- I don't want to paraphrase your testimony, I'm not real good at; that.

A. I don't want to paraphrase my

testimony either. What did I say at the beginning?

Q. Do you have any recollection of the conversation now?

A. It's been erased or it's been diminished a little bit, something about Dr. Devereaux' opinion of when this could have or a should have been treated, okay, maybe in a general way I should address that.

If Dr. Devereaux says Mrs. Nabozny should have been treated let's say a week before she was, which would take it to the 16th, I don't. see that it was reasonable to treat her on the 16th and I'm not willing to say that it would have prevented the whole problem.

Let's yo back another week or right after the extraction. If he says two weeks, like he says in his report, *yes*, I think that would make a difference.

I don't think there is any way either anyone could have treated her on reason or on medical soundness but, sure, if we had given her antibiotics, powerful antibiotics, and opera-Led on her to give them to her two

weeks before the 23rd, yes, that would have made a big difference.

Q. Two weeks before the 26th?

A. Two weeks before the 26th, yes, I think that would have made a difference, but as we approach that time frame beyond which things start to make a difference, I don't see how you can squeeze it into a certain short time frame like certainly days and, furthermore, I don't see how you can recognize a condition until late on anyway.

Now, that in a very vague and perhaps unhelpful way is what I feel is relevant to her care by Dr. Chepla.

Now, what Dr. Devereaux said specifically, maybe you can tell me and then I'll comment on that or tell me as a general issue and I'll comment. on that.

MR. DeSANTIS: Well, I'd rather not paraphrase his testimony either. I think you've answered my question and with khat, I don't think I have any further questions.

Let me have one minute though to review my notes to make sure that's a fact, off the record.

(Discussion off the record.)

MR. DeDANTIS: No further questions. I appreciate your patience and your time.

Having gone through depositions before, you understand that you have the ability to review a deposition and sign it if you want to take advantage of that opportunity or you can waive your signature at which point your deposition may be used at trial without your prior review.

THE WITNESS: I will not take advantage of that opportunity and I will waive.

(SIGNATURE WAIVED.)

- - - - -

CERTIFICATE

The State of Ohio,)

SS:

County of Cuyahoga.)

I, Tia G. Moseley, a Notary Public within and for the State, of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, DONALD C. MANN, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 1st day of June, 1989.

Tia G. Moseley

Tia G. Moseley, Notary Public within and for the State of Ohio

My commission expires March 14, 1991.

CURRICULUM VITAE (1989)

NAME: Donald Charles Mann
BIRTHPLACE: Indianapolis, Indiana (June 1, 1943)
ADDRESS: 1611 South Green Road, Cleveland, Ohio 44121

EDUCATION:

Indiana University Medical School Indianapolis, Indiana Doctor of Medicine	1964-1968
Indiana University Medical Center Indianapolis, Indiana Intern, Straight Medicine	1968-1969
Bowman Gray School of Medicine - No. Carolina Baptist Hospital Winston-Salem, North Carolina Resident, Neurology	1969-1971
Washington University School of Medicine - Barnes Hospital Washington University St. Louis, Missouri Resident, Neurology	1971-1972
Major Medical Corp., United States Army Assigned as neurologist to U.S. Army Hospital, Japan	1972-1974
Private Practice, Neurology Cleveland, Ohio	1974-
Coordinator CME, University Hospitals	1982-1986

APPOINTMENTS:

Senior Clinical Instructor in Neurology Case Western Reserve University, School of Medicine	1974-1978
Assistant Clinical Professor of Neurology Associate Clinical Professor of Neurology Case Western Reserve University, School of Medicine	1978-1986 1987-
Assistant Neurologist University Hospitals of Cleveland	1974-
Assistant Clinical Professor of Medicine Department of Medicine University of Hawaii School of Medicine	1973-1974

COMMITTEES:

University Hospitals

Utilization and Medical Audit	1979-1983
Medical Records, Chairman	1980-
Quality Assurance	1980-1984
CME Committee	1983-1986

CWRU School of Medicine

Associate in Continuing Medical Education	1982-1987
COCME Committee	1983-1987

University Suburban Health Center

Board of Governors	1977-1983

PPRO, AREA VI, Trustee	1983-1987

CERTIFICATION: Certified in Neurology by the American Board of Psychiatry and Neurology
October, 1974

LICENSE TO PRACTICE MEDICINE: State of Ohio, 1973
State of Indiana, 1968

PUBLICATIONS: Mann, D., Pearce L., Waterbury, D. "Amantadine for Parkinson's Disease"

Mann, D., Toole, J. "Cranial Arteritis with Liver Involvement: Stroke, 3:131-134, 1972

PROFESSIONAL MEMBERSHIPS: Ohio State Medical Association
American Academy of Neurology
American Academy of Neurology Practice Committee 1986-1987

NEWSLETTER EDITOR: Neurology 1986-

SUMMARY OF DR. CHEPLA'S OFFICE RECORDS

July 8, 1986 — 11 Extractions (2, 3, 4, 5, 12, 13, 15, 16, 18, 31 and 32). #17 - impacted.
Antecubital Fossa Versed 10 mg. Talwin 30 mg. Brevital 80 mg.
Normal sinus rhythm--80 beats per minute.
Maxillary right and left alveoplasty.
Tylox (15)
8:42 called patient and found to be "okay."

July 15, 1986 — Suture removal--healing well--complaining of pain in right ear, possible TMJ pain.

July 18, 1986 — Post-operative treatment, slight edema---right face over paratid gland area--tender.
Impression--possible paratid gland swelling infection.
Prescribe Keflex 500 mg. (30 tablets).
One week follow-up.

July 22, 1986 — Complaint of severe pain--right facial area.
Pre-auricular with radiating pain to forehead, complaint of numbness of left chin area now.
Pain in slight edema. over right paratid and TMJ area.
Without external auditory meatus pain on palpation.
Plan continue Advil and ~~Tylox (15)~~ Fiorinal #3 (15).
Minimal edema,. healing. Heat to right face.
Healing well clinically. Follow-up 48 hrs.

July 24, 1986 — Patient called--complains of drooping right face.
Referred to neurologist at Hillcrest Hospital.

July 25, 1986 — Called Cole 461-3381--he did not return call.

July 28, 1986 — I called Cole--ptyergoid fossa abscess--incision and drainage--last Saturday p.m. by Dr. Rusch.
Patient responding well to treatment.

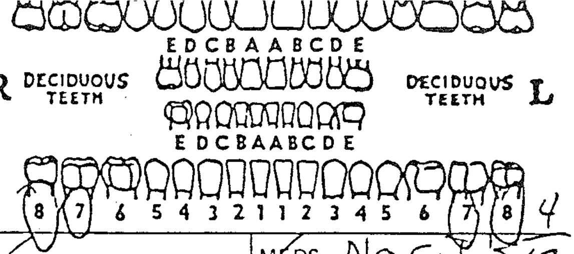
August 1, 1986 — Called Hillcrest, condition is satisfactory.

Nov. 3, 1986 — Patient not home.

Nov. 12, 1986 — Called patient--not home.

Nabozny, Kathy 37

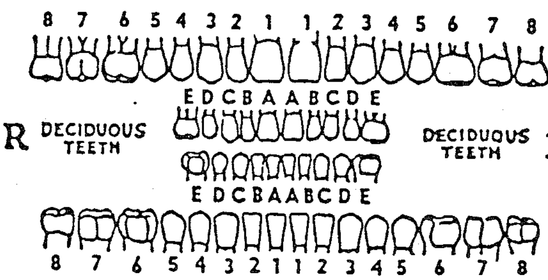
Address 14630 Irwin	Burton
Referred. Sangrik	M.D. Fernadeiz
Tel 834-1605	Emp. Allen-Bradley



Heart	Rheum. Fever	Diabetes		MEDS No C.T. 512
Kidney	Tuberculosis	Thyroid	Preg.	
Anemia	Asthma	Epilepsy	NPO yes	
Bleeding	Pneumonia	Allergy DCN	HTN 150/98	

Date	Ins. Service	Debit
7-8-86	11 ext (# 2,3,4,5, 12,13,15,16,18,31,32)	330 —
Ok	#17 Imp	115
8:42	Ⓡ ACF VR-10 Tal-30 O₂-80	95 —
	NSR -80	
	Max RDL alter	150
	Tylox (15)	690 —

Patient NABOZNY, KATHY ②	Age 37		
Address			
Referred	M.D.		
Tel.	Emp.		



Heart	Rheum. Fever	Diabetes		
Kidney	Tuberculosis	Thyroid	Preg.	MEDS
Anemia	Asthma	Epilepsy	NPO	
Bleeding	Pneumonia	Allergy	HTN	

Date	Service	Debit
7-22-86	[illegible] cont - advil. ~~#Tylox (15)~~ (from #2/15)	
	[illegible] edema, [illegible] Ⓡ [illegible]	
	well clinically. F/U 4 wks.	
7-24	Pt called c/o drooping Ⓡ face	
	referred to [illegible] at	
	Hill Crest Hosp. -	
7-25-86	- called [illegible] 461-3381 - [illegible]	

7-15-86 ... c/o pain (R) ... TMJ pain -

7-18-86 ... st. ... (R) face over parotid g. ... tender.
Impr - poss. parotid g. swelling ...
Rx ... Keflex 500 (30)
... FILL.

7-22-86 c/o severe pain (R) facial area pre auricular, & radiating pain to forehead, c/o numbness of (L) ... area ... .
... (R) parotid ... TMJ, ... EAM pain ...

Date	Service	Debit
	did not return call.	
7-28-86	I called Coll - ... fossa abscess ... Tx by Dr. ...	
	pt. responding well to Tx.	
8-1-86	called Hillcrest, condition is satisfactory	
11-3-86	pt. not home	
11-12-86	called pt. not home	

PLAINTIFF'S EXHIBIT 3 Mann

7/10/ extraction - Chappa
7/10 Hard to open mouth & pain (Rusch
7/12 R temp [illegible] pain Cole
7/15 OV Pain R ear Chaplin (15 m)
7/13 Numb R Chin (cole) - ~~pain~~ tone R face (Chaplin)
OV edema R face - 1 kefley OV problem planned
7/22/86 R tongue numb R lower lip
R V TV hypes numb + R low - no trismus (Cole)
7/23 - cole OV OV -> pain R ear ~~pain~~ numbness Kahn
7/24 CT negative, SA R VII
7/25 Cole Gallium scan - petrositis MRI Cole
7/26 I & D Varsonally Rusch
Clindamycin ev of 25 h
7/28 Vancomycin, Gentamycin
8/13 Catheter [illegible]
8/14 Antrotomy (Rodemann)
9/14 d/c [illegible] PO Clindamycin
10/15 Numb R corner of mouth
+ R Tongue

- Form quietly to Na
- did delay

no interp Na
antibodies

no way be covered have them
which antibody
or anyone at all

DONALD C. MANN, M.D., INC.
UNIVERSITY SUBURBAN HEALTH CENTER
1611 SOUTH GREEN ROAD
CLEVELAND, OHIO 44121
TELEPHONE 381-2673

(Copy)
Exhibit 4

February 22, 1989

Eugene B. Mador, Esq.
Kitchen, Messner & Decry Co.
1100 Illuminating Building
55 Public Square
Cleveland, Ohio 44113

Re: Kathleen M. Nabozny
Pile No.: 3480-A-3065

Dear Mr. Mador:

I have reviewed the following records in connection with Mrs. Nabozny's cace: (1) office notes of William Chepla, D.D.S., (2) office records of Monroe Cole, M.D., (3) report of Michael Devereaux, M.D., dated August 19, 1988, (4) the Hillcrest Hospital records dating from July 23, 1986 to September 4, 1986, (5) depositions of Dr. Chepla, Dr. Williams, and Mrs. Nabozny and, (6) report of Ira Williams, D.D.S. and Patrick Metro, D.D.S.

Mrs. Nabozny had a routine extraction on July 8, 1986 and returned to Dr. Chepla's office on the 15th for suture removal and reported pain in the right ear. Three days later, on the 18th, she was treated for edema over the parotid gland, presumed to be due to infection and she was placed on a broad spectrum antibiotic. Four days later on the 22nd, she had more pain and a new symptom of numbness. This constitutes the first appearance of the specific symptom which may have a neurologic basis depending, to some degree, on how the patient uses the word numbness and what she means. Up until this point, there is nothing suggestive of any disorder of peripheral nerves. However, when she developed weakness of the right face, a day later, she was given a referral to a neurologist.

The initial evaluation by Dr. Cole on the 23rd, revealed subtle, perhaps borderline findings in facial movements and a loss of sensation over the third division of the trigeminal nerve. She apparently had no difficulty opening her mouth. She also had a perplexing numbness in the right fourth and fifth fingers and right fourth and fifth toes

which would localize the problem to the brain itself or the brain stem within the parenchyma rather than to the peripheral nerves in the face.

It took another two days to diagnose the condition by Gallium scan and on the 26th, she was placed on antibiotics beginning the treatment of the rare condition of pterygopalatine fossa abcess.

I believe the earliest this condition could have been diagnosed would have been sometime after the 18th of July and, even then, there would have hardly been a reasonable clinical suspicion of a deep facial abscess.

This is such an unusual abscess that in diagnosing it one has to look at not when that specific condition was identifiable but when the index of suspicion to anything being amiss was raised and, hence8 the need for additional testing. Assuming a three day delay between the suspicion of the abnormality and the treatment (from the 23rd to the 26th), the absolute earliest that an abnormal condition could have been suspected (but certainly not diagnosed) would have bean around July 22nd. Even then a complaint of numbness in a patient with edema of the face must not be taken to mean that it is of neurologic origin.

Using the clinical material that Dr. Chepla had at hand, he could not have had a heightened awareness of a peripheral nerve compromise or an abcess until around the 22nd, 23rd, or 24th, of July. Given the complexity of the diagnosis and additional days necessary to confirm and treat hec condition, it is splitting hairs to assume that a feu days could make much difference one way or another in the outcome. Judging from the very subtle signs and symptoms and the arcane type of condition she did develop, I believe the earliest anything amiss of a significant nature could have been suspected was when Dr. Cole saw her on the 23rd of July. A less astute examiner might actually have been delayed further in suspecting what was wrong.

The permanent numbness she is left with is, in a general way, less likely to have occurred if she had been placed on the specific antibiotics that were effective against the organism. It is stretching it a bit to assume that had she been put on antibiotics the 23rd, or the 24th, that she would not have numbness today.

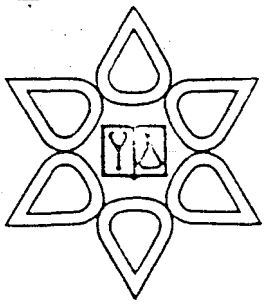
The notable things about this case are the speed with which a very difficulty diagnosis was made and treatment instituted, and the

fact that she had a treatment for the condition, while undiagnosable at the time the Keflex was started, which could have been effective for a facial infection.

Yours sincerely,

Donald C. Mann, H.D.

DCM/eb



THE MT. SINAI
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Cleveland, Ohio 44106-4198

216/421-3813

Department of Medicine,
Division of Neurology

Michael W. Devereaux, M.D.
Krishan Chandar, M.D.
Michael F. Bahntge, M.D.
Gerald. E. Grossman, M.D.
David E. Riley, M.D.

August 19, 1988

Mr. Richard G. Zeiger
KAUFMAN & CUMBERLAND
1404 East Ninth Street .
Suite #300
Cleveland, Oh 44114 .

RE: Kathleen M. Nabozny

Dear Mr. Zeiger,

At your request, I saw Kathleen Nabozny, a 39-year-old, right-handed woman, for. a neurologic evaluation today. The history was obtained from the patient. I also had available for review pertinent medical records which included the following:

- Hospital chart from Hillcrest Hospital admissions: 07/23/86 to 09/04/86
- July 23, 1986 neurologic evaluation report of Monroe Cole, M.D., as well as his 09/22/86 and 10/15/86 follow-up notes.
- Office records from William E. Chepla, D.D.S. the patient's oral surgeon. ..
- Office records from Larry J. Sangrik, D.D.S. the patient's dentist.

Problem:

PERSISTENT NUMBNESS RIGHT CHIN, RIGHT SIDE OF THE TONGUE AND RIGHT SIDE OF THE MOUTH, along with a tingling sensation within the right external auditory canal dating back to complications arising from dental extractions, July 8, 1986.

Affiliated with Case Western Reserve University School of Medicine *and The Jewish Community Federation*

Present Illness:

The patient was in her usual state of stable health until July 8, 1986 when she underwent multiple tooth extractions (11) because of extensive dental caries and periodontal disease. The patient states that approximately 3-4 days (4 days, according to Dr. Cole's report), she developed pain in the right side of her face ("right temperomandibular region and the left temple", according to Dr. Cole). At about this time or shortly thereafter; she also developed difficulty opening her mouth (trismus). She was seen in follow-up on several occasions during this time without a definite explanation uncovered. The pain continued to increase. Approximately 10 days after surgery, she developed numbness in the right cheek and she was started on Keflex. About 2 weeks after the surgery she noted numbness in the right half of the tongue and over the right lower lip to the midline. Also about this time she developed tingling in the 4th and 5th digits of the right hand, and 4th and 5th toes of the right foot. The patient's oral surgeon, Dr. Chepla; an hearing the symptomatology, told the patient she needed to see a neurologist.

The patient contacted Dr. Monroe Cole's office on July 23, and fortunately his office staff recognized the potential seriousness of the problem and he saw her immediately on July 23, 1986. According to his report, there were no symptoms referrable to the cranial nerves other than the above described sensory complaints.

His neurologic examination demonstrated the following findings:

- Slight fullness of the right side of the face.
- Slightly larger right palpebral fissure compared to left palpebral fissure.
- Minimal lag of the right comer of the mouth on spontaneous smiling.
- Marked tenderness anterior to the right tragus.
- Impaired tongue protrusions secondary to pain.
- Absent deep tendon reflexes.
- Decreased pin appreciation right side of the face: equivocal right 1st division, definite 2nd division, and maximum 3rd division with anesthesia of the right side of the tongue.

Dr. Cole correctly diagnosed an EXTRACRANIAL INFECTION on the right side of the face and had the patient admitted on an emergency basis for appropriate evaluation and treatment. As an aside, he was puzzled by the numbness of the right fingers and toes described above. In my mind, I cannot explain this. Fortunately, these symptoms resolved early in the course of her hospitalization.

The patient's hospitalization was lengthy and I will review only the highlights. She underwent a series of diagnostic tests including: CT SCANS of the face and head, MRI SCAN of the face and head, as well as various other

types of x-ray evaluations of the face and jaw. Studies revealed an abscess in the right pterygopalatine fossa. In addition, there was complete opacification of the right maxillary antrum due to sinusitis. She was seen by a number of physicians, including Doctors Alperin and Ruch, oral surgeons, Dr. Scott Burg, a rheumatologist, and Dr. Dudinsky, an internist, with expertise in infectious disease. Treatment included aspiration of the right temperomandibular joint and drainage of the pterygopalatine abscess. She was also seen by Dr. Erwin Readerman, an otorhinolaryngologist for maxillary sinus surgery. She was treated for 42 days with Clindomycin administered through a Hickman catheter, which was inserted by Dr. George Anton on August 13, 1386.

The patient gradually improved over her prolonged hospitalization. According to the hospital notes, there was some improvement in her pain followed by an increased ability to open her mouth. There was also some improvement in her facial sensation, particularly over the .forehead and cheek. She was monitored closely during this time by Dr. Cole. As already mentioned, the numbness in her fingers and toes resolved relatively early in the course of her hospitalization.

After discharge, she was seen on several occasions by Dr. Cole. On his September 22, 1986 follow-up, he noted that there had been complete resolution of her facial pain. He stated that for the first time on September 22, the patient experienced a few bouts of numbness on the right side of the face and right side of the tongue. He stated that his neurological examination was otherwise normal (I am not clear from his note as to whether she had objective findings of loss of sensation within the mandibular division of the right trigeminal nerve at that time). The patient tells me that she had persistent numbness. What she reported to Dr. Cole at that time is a peculiar sensation of transient "hardness" over the chin. She states that it actually feels firmer in the region of numbness over her right chin during these bouts than at other times. Her family and friends have not noted any change in her face during these periods.

Dr. Cole saw her once again on October 15 and noted that the patient's complaints were "continued numbness of the right corner of the mouth and right edge of the tongue, and also limitation of jaw opening." He stated that the examination was otherwise normal. Again, I am uncertain what positive findings his examination revealed. I presume that she continued to have decreased sensation within the trigeminal nerve. Dr. Cole noted in his discharge summary of 09/24/86 that the neurological examination was normal except for diminished sensation on the right side of the face.

The patient continues to have sensory disturbances in the right side of the face. Her present symptoms have not changed appreciably over the last year and a half. She has marked decreased sensation over the right mental region and right lower lip. There is a feeling of wetness or drooling in this area although there is no actual drooling from her experience of wiping this area many times with her hand or a cloth. There is a marked decreased sensation on the right side of the tongue. The tip of the tongue is tingling, but the back of the tongue feels numb and "fat." The right lower gums and the right buccal mucosa are also numb. She states that the whole area feels like it has been injected with Novacaine similar to the sensation one has when given an injection of Novacaine by a dentist. She has also noted that when she places

a Q-tip in the right external auditory canal, there is a feeling of tingling in the inferior canal region. The ear, as well as peri-auricular regions have normal sensation. When the area is not being touched with a Q-tip she has no abnormal feeling. She also has some chronic pain in the right tempero-mandibular joint region. She states that she has been told there is damage to the right "jaw joint" from the infection. She also states that for a number of months following discharge there was a feeling of "drawing" of the right side of the mouth. There was evidently a perceptible droop of the right side of the mouth. This is presumably a continuation of what Dr. Cole noted on his initial examination. This cleared spontaneously after approximately 6 months. Presumably on the basis of the patient's history and Dr. Cole's examination, she had subtle involvement of the right facial (cranial nerve VII) nerve.

The patient denies any other neurologic symptoms at the present time.

Past Medical History:

She was diagnosed as having possible pernicious anemia in the hospital, based on a low B12 level. The first Schilling test was completed during hospitalization, but a second test had not been done by the time she was discharged. I do not know how well established this diagnosis is since I do not have any information about it following her hospitalization. She is receiving B12 shots. She smokes 1/2 pack of cigarettes per day. She is obese. There evidently has been some high blood pressure in the past, but she is not being treated at the present time. She underwent right knee surgery 3 weeks ago and she is currently in a leg brace and walking with crutches. She has also had a Caesarian section in the past and a tonsillectomy when a child. She does not drink to excess.

Family History:

Non-contributory.

Social History:

The patient is an electronic assembler. She has one teenage child.

Neurological Examination:

Mental Status:	Alert, oriented x3. Cognition intact.
Speech:	Normal without evidence of dysphasia or dysarthria.
Skull:	Normocephalic without bruits.
C-Spine:	Full range of motion; no bruits heard.
Spine:	Normal without abnormal curvature.

Neurological Examination:

Cranial Nerves:

II:	Fields were full and the fundi benign. Acuity normal.
III, IV, VI:	Extra-ocular motility full. Pupils 3 mm equal, round and reactive to light without afferent pupillary defect. No nystagmus. Lids normal.
V:	Marked decrease in pin appreciation in the right mental region, right lower lip to the midline, right side of tongue, right lower buccal mucosa, right gum to midline. Sensation was normal in the right mandibular region over the ramus of the jaw. Maxillary and ophthalmic divisions were also normal. Corneal reflexes intact. Jaw muscles appeared normal in strength on the right side (as well as on the left side).
VII:	No definite weakness on right side of face.
VIII-XII:	Normal
Motor:	Normal and symmetrical power and tone. Right lower extremity was not tested in detail because of recent knee surgery.
Coordination:	No evidence of dysmetria or dysdiadochokinesis. Gait would not be adequately tested because of recent knee surgery.
Reflexes:	1 to 2+ throughout and symmetrical with the exception of the right knee which was not tested because of recent surgery. Left knee was 1+ with reinforcement. Toes were downgoing and there were no Hoffmann's signs.
Sensation:	See cranial nerve V above. Pin, temperature, vibration, position sense normal in the extremities, including thr 4th and 5th toes of right foot, and 4th and 5th fingers of right hand.

Summary:

The patient is a 39-year-old, right-handed woman who had 11 dental extractions July 8, 1986, followed by gradual increasing pain right side of face, swelling of right side of face and numbness of right side of face. Neurologic evaluation 15 days post-op revealed disturbances in the right trigeminal nerve, probably minimal disturbance of right facial nerve, trismus, and swelling of

right side of the face. The patient was admitted to the hospital for a work-up of suspected facial abscess. A right pterygopalatine abscess was found. She was treated aggressively with a combination of surgical procedures and antibiotics. From the laboratory reports available to me, she had a staphycoccus infection.

Following hospitalization treatment, she was left with numbness and paresthesias of the right tongue, right buccal mucosa, right gum, right mental region, with some persistent pain in the right temperomandibular region, as well as paresthesias in the right external auditory, canal when touched with a Q-tip. She equates the sensory disturbance as being similar to sensation of numbness when given an injection of Novacaine by a dentist.

Neurological examination today revealed evidence of sensory loss:

- right mental. region
- right lip
- right buccal mucosa
- right lower gum
- right side of tongue without evidence of weakness of muscles of mastication

IMPRESSION: - NEUROPATHY OF THE MANDIBULAR DIVISION OF THE RIGHT TRIGEMINAL NERVE (buccal branch of the anterior division of the mandibular division of the trigeminal nerve, lingual nerve of the posterior division of the mandibular division of the trigeminal nerve, inferior alveolar nerve of the posterior division of the mandibular division of the trigeminal nerve, and possibly small branches of the auriculotemporal nerve of the posterior division of the mandibular division of the trigeminal nerve)

Comments:

In my mind, there is virtually no doubt about the organic basis of the patient's symptom complex. I suppose one could challenge the symptoms on the grounds that the findings and impression are based on the patient's response to pin prick and light touch, as well as temperature appreciation. I do not believe the patient could be making this up since very few human beings would have the knowledge of the anatomy of the trigeminal nerve that would permit fabrication of a sensory disturbance like this patient has. In other words, the finding, in my mind, is absolutely organically based.

I presume that the sensory disturbance was related to direct compression of the trigeminal nerve in the region of the pterygopalatine fossa. This certainly was not due to damage to the nerve related to the dental extractions. The patient did not have any sensory disturbance on the right side of her face until approximately 10 days after the dental extractions. Presumably, the abscess had reached a size by that time to produce compression. I have to presume that the persistent compression, until Dr. Cole's diagnosis led to appropriate treatment, resulted in irreversible damaged branches of the

mandibular division of the right trigeminal nerve resulting in the patient's chronic sensory disturbance.

It has been over 2 years since her symptoms first developed. I, therefore, believe that there is no chance her symptoms will dissipate. In other words, I think that she will have her present symptomatology for the rest of her life. The symptomatology she has must be very annoying as I suspect most adults know who have had Novacaine injections to the mandibular division of the trigeminal nerve affecting primarily the alveolar and lingual branches. The numbness of the tongue, buccal mucosa, and particularly the numbness of the lip and chin (mental region) is quite annoying. From personal experience, I know what she means by the feeling of wetness over the lip/chin that she reports since I have experienced the same sensation during local anesthesia for Novacaine.

Although I admit to the ease of practicing medicine by hindsight, I do believe that had the problem been recognized sooner than 15 days post-operatively she might not have been left with permanent damage of the mandibular division of the right trigeminal nerve. The patient's ongoing problem is unfortunate.

I conclude by saying that the treatment she received, beginning with Dr. Monroe Cole's initial examination 18 days after surgery, was exemplary and beyond reproach. His quick action may have saved this patient's life or at least more extensive, permanent neurologic insult.

Thank you very much.

Respectfully,

Michael W. Devereaux, M.D.
Chief, Division of Neurology
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MWD:dr
09/02/88