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

IN THE COURT OF COMMON PLEAS

JACK ANDREWS, et al.,
plaintiffs,

vs. : Case No. CV 98 124723

ALICE DENTON, M.D., et al.,:
defendants.

Deposition of ANTON P. MILO, M.D., a defendant herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Kris A. Adorjan, Notary Public within and for the State of Ohio, at the offices of David M. Best, Esq., 4900 West Bath Road, Bath, Ohio on FRIDAY, MARCH 26TH, 1999, commencing at 9:31 a.m., pursuant to agreement of counsel.

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I N D E X

WITNESS: ANTON P. MILO, M.D.

NO EXHIBITS MARKED

(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

ANTON P. MILO, M.D.

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

MISS KOLIS: Good morning, Dr. Milo, as you know we have just been introduced. My name is Donna Kolis. I have been retained to represent Jack Andrews, now known as the Estate of Jack Andrews, as Jack Andrews passed away about a week and a half ago.

I'm going to ask you a series of questions today about the office notes which you previously provided to me.

Let me say for purposes of the record, if I ask you a question that you don't understand, let me know that you don't understand the question; can I secure your agreement on that?

THE WITNESS: Yes.

MISS KOLIS: The reason I state it that way, if I ask a question and you do answer it, I will be relying upon the answer and assume you understood it.

CROSS-EXAMINATION

BY MISS KOPIS:

Q Doctor, have you had the opportunity previous to today to give a deposition?

A Yes. I have.

Q Are instances where you gave a deposition, was it in medical/legal litigation?

A Yes, it was.

Q Have you prior to this particular action been sued before for medical negligence?

A Yes. I have.

Q Do you know approximately how many times?

A Once.

Q Was that also in Summit County?

A Yes.

Q How did that litigation terminate?

A. I was found innocent.

Q Did that case actually go to trial?

A Yes, it did.

Q Fair enough. Doctor, prior to ever filing a lawsuit, as you may recall from looking at your chart, I requested that you send me your office records, and those did come to me through Record Deposition Service; do you recall having your office assemble those records?

A. It's been a while.
Q. You probably didn't put them together yourself?
A. No.
Q. Did you bring with you your office chart?
A. I did.
Q. May I take a quick look at it?
MR. BEST: Let me take a quick look before you do that. I didn't get a chance to do that.
MISS KOLIS: Do you have a copier, David?
MR. BEST: Yes.
MISS KOLIS: Apparently when your office photocopied this they forgot to copy the back side of the examination page. I don't have that one, that one is not in my chart. It's not a big deal.
MR. BEST: Let's make sure what page we are talking about.
MISS KOLIS: The back side, that's the page I don't have.
Q. In the records which were supplied to me, which we are going to talk a little bit about today, there were pages that looked like office

telephone notes?
A. Yes, ma'am. It's in the back, ma'am.
Q. Oh, the yellow stickies. Thank you. Mr. Best obviously will supply me with the secondary page.
This morning I was provided with a copy of your curriculum vitae. I want to briefly go over it.
It appears you graduated from medical school from Ohio State University?
A. Correct.
Q. About 1960?
A. Correct.
Q. You did an internship in Hawaii?
A. Yes, in the Army.
Q. That's how you got the privilege *of* going to Hawaii, you were in the Service?
A. I went directly into the Army after medical school.
Q. You did your pre-specialty surgical training at another Army facility, Fort Dix?
A. Yes, New Jersey.
Q. Then you did your ENT residency which you completed in 1965 at Walter Reed?
A. Correct.

Q. Then you served as director of the Army Hearing & Speech Center?
A. Correct.
Q. You did further postgraduate studies in audiology?
A. Correct.
Q. You came to Akron in 1970?
A. Yes.
Q. When you came to Akron what kind of practice did you go into?
A. Ear, nose and throat, and head, neck surgery.
Q. Are you a surgeon, Doctor, at present?
A. Yes, I am.
Q. When were you certified in otolaryngology, which I can hardly ever pronounce, is that 1965?
A. That's when I completed my residency. I took the Boards in 1967.
MR. BEST: Peter, do you have this page?
MR. VOUDOURIS: Actually, I think I do.
MR. BEST: I thought everybody did.
MR. VOUDOURIS: I think Records Deposition Bates stamped it as 4.

MISS KOLIS: It's possible.

MR. BEST: These are extras of his CV and bill.

I want to make sure this is in the right order; is that correct?

THE WITNESS: Yes.

Q. Doctor, are you Boarded in surgery?

A. No, just in otolaryngology, and head, neck surgery.

Q. What kind of head and neck surgeries do you perform?

A. Benign and malignant tumors, surgery of the head and neck.

Q. Fair enough. Did you open a private practice, did I understand that correctly?

A. Yes, I started as a solo surgeon in 1970.

Q. At that time what hospital did you affiliate with, or where did you have privileges is a better question?

A. Akron City, Saint Thomas Hospital, Children's Hospital Medical Center in Akron, and Akron General Medical Center.

Q. Has that remained the same through the years?

A. Yes.

Q. So you still have privileges at all of the

same facilities?
A. Yes, ma'am.
Q Where is the majority of the surgery that you perform conducted?
A Most of it is in Akron City Hospital, now called Summa Health Systems, and Children's Hospital Medical Center.
Q Doctor, what I want to do is go over the office notes you prepared on Mr. Andrews
In preparation for today's deposition did you have an opportunity to review any medical records?
A. Besides mine?
Q. Right.
A. Yes, I have.
Q What records have you actually reviewed to the best of your recollection?
A The patient's Saint Thomas Hospital records of December, '96, and his Akron City Hospital records of I believe July, '97 A quick review was performed on those records
Q When of course you had an opportunity to look at your own chart?
A. Correct.
Q. If at any time I ask you a question and you

need to refer to your own records, feel free to do so.

You initially saw Mr. Andrews on a consultation requested by Dr. Stringham; is that correct?

A. Correct.

Q. Now, I read the letter that was sent to you, it was dated September 10th, 1996, if you would like to take a look at it?

A. Yes, ma'am.

Q. The first question I need to ask you, after you received the letter, did you have an opportunity before you examined Mr. Andrews to speak directly with Dr. Stringham or Dr. Alice Denton?

A. No, I did not.

Q. I'm not asking you to guess what was in Dr. Stringham's mind; however, based on the letter you received, what did you believe the purpose of the consultation was?

MR. VOUDOURIS: I'm going to object. *Go* ahead, Doctor. *Go* ahead, you can answer. She is asking you what you thought what someone else's mindset was.

Q. I am not asking you to get into someone

else's mind, but since you indicated you didn't have the opportunity to speak with him, this document is the one that you would have read and determined what the purpose of the consultation was for; what did you believe your consult was being conducted for?

A. This letter of introduction covered the patient's medical history, and I believe the main impression they wanted answered or worked on was the subacute mastoiditis.

Q. The sentence says, **I** would appreciate you seeing him in consultation for Dr. Denton regarding this questionable subacute mastoiditis, correct?

A. Yes, paragraph Number 3.

Q. Did you interpret that to mean they were not certain that the diagnosis was subacute mastoiditis, and would like more expert input as to what the findings actually indicated?

A. The word questionable makes me think that.

Q. Just so I can get oriented, although there is not that many handwritings in the chart, the little handwriting on the top indicating have patient bring in CT and MR with him for his office visit on 9-26; is that your handwriting?

A. Yes.

Q. Any time I see writing that looks like this that's probably you?
A. Correct.
Q. So you wanted the patient to bring in this CT and MR, and from review of your chart the patient did do that, didn't he?
A. This note at the bottom preceded that in the time sequence; can we go there?
Q. Absolutely.
A. I got the letter and there was no report, scan report, so I asked Joyce who was my secretary at that time to send for the copy of the MRI scan, and they faxed it to me. Then after reading that the next day I made the note to have the patient bring the films with him at that appointment.
Q. Why did you want the patient to bring the films with him?
A. I wanted to have the films available to help quantify what the radiologist reported.
Q. When you say to help quantify what the radiologist reported, are you indicating that the report wasn't clear to you, or that you just wanted to independently look at the films, or neither? I'm not sure what you mean by quantify.
A. The MRI scan report showed certain pathology,

and I wanted to see if I saw what the report or the impression stated, the radiologist's impression stated.

Q. Can you turn to your copy of the MR report?

A. Yes.

Q. That's what you would have seen obviously before the patient came in that led you to conclude that you wanted him to bring his films in; am I stating that accurately?

A. I wanted to review this.

I want to go on the record now that I am not an expert in reading MRI and CAT scans, it was strictly to see if I saw what was reported in the impression.

Q. When you said you felt there was some pathology reported that you wanted to, you might not use this word, visualize, which pathology were you referring to on this MRI report?

A. Impression 2 and 3.

Q. Let me ask you this question -- first of all, I guess let's deal with the impressions. Mucosal thickening, right maxillary sinus, what if anything does that finding on an MRI suggest to you as an ENT?

A. They used the word moderate, I wanted to

quantify that, and it indicates there was swelling of the lining of the sinus, it could be from allergies, sinus infection.

Q. Could that kind of swelling in the sinus cavity be caused by neoplasm in the nasosinal cavity?

A. If isolated in one area, this was a generalized swelling. In my opinion it wasn't mentioned, it didn't mention a tumor or malignancy, so I assumed it was generalized swelling.

Q. The films that were taken, the MRI of the brain, you did get to see it, correct, would that have been able to determine a tumor in the nasosinal cavity?

A. It shows that area, you can see the sinuses, obviously enough to make a comment to that effect.

Q. Did you note the radiologist's comment; first of all, do you know Dr. Pepe?

A. I know him very well.

Q. Dr. Pepe indicated, just above his impressions, and I think I am reading this correctly, defined detail of the mastoid region is better imaged with section CT of temporal bone; have you seen that kind of report from Dr. Pepe previously?

A. I don't recall.
Q. Do you think he was indicating that there was yet another examination that could be performed to better define the area?
A. He suggested a CT scan of the temporal bone in the text of the report, not in the impression. The impression stated that there was a recent CT scan and revealed sclerosis, suggesting chronic changes, so I assumed that was sufficient.
Q. Chronologically the CT that had been performed actually occurred before the MRI; do you agree with that?
A. Correct.
Q. The CT that was performed, you have that report?
A. Yes, I do.
Q. That did not image the mastoid region with specificity, did it?
A. It's not specified in it.
Q. Wasn't that CT one of the head?
A. Correct.
Q. Did you get the conclusion from looking at the films or from reading the report that the mastoid region had actually been imaged?
A. I really had no comment on the CT scan.

Q. Fair enough. The secondary finding you were concerned with was fluid in the mastoid region?
A. Correct.
Q. The indication by Dr. Pepe is that could represent an inflammatory process?
A. Correct.
Q. When a radiologist is reporting to you as the ENT that there is fluid in a particular region that could represent an inflammatory process, does that exclude the possibility that that fluid being imaged on this MRI is actually fluid caused by a neoplasm of some sort?
A. It's one of the possibilities.
Q. That's all I wanted to know.

Doctor, obviously you had received your consult letter, you looked at the report of the CT and MRI, and then you asked the patient to come into the office of course and bring those with him and he did so.

I will probably go through your actual examination, but what I want to do is switch to the consult report that you ended up writing, if we could go there first.
A. Yes, I have it.
Q. Tell me in your own words, and you can use

them out of this report, or however you wish to communicate it to me, what was your diagnosis or diagnoses for Mr. Andrews at the conclusion of your examination; and it was September 26, 1996, correct?

A. Yes.

Q. As I said, what were your diagnosis or diagnoses?

A. Again, the consultation asked probable diagnosis, question mark, subacute mastoiditis, that guided my attention to that problem.

Based on my findings, the results of the hearing test that he had that same day, he had what we called serous otitis media, which means fluid in the middle ear, and did not indicate subacute mastoiditis.

He had mucosal thickening in the right maxillary sinus, which I attributed to allergies or low grade infection. Sinusitis many times causes fluid in the ears, the most common cause.

Q. You didn't believe he had subacute mastoiditis, I think that's what you just said. You thought he had serous otitis media? I forgot to write as you were speaking.

A. Yes.
Q. In addition you felt he had sinusitis?
A. Mucosal thickening of the right maxillary sinus, sinusitis or allergies.
Q. Which of the two diagnoses that you have just named would be responsible for a headache behind the right eye, right temple, and back of the head?
A. None of these findings are the cause of that type of pain.
Q. What did you believe, if you had a belief of a diagnosis, was the cause of those pains that I just mentioned behind the right eye, the right temple, and back of the head?
A. Based on the introductory letter it was cluster headaches as diagnosed by Dr. Denton.
Q. Now, you gave him your own personal examination, and as an ENT what other conditions would cause those kind of symptoms that you would be treating?
MR. BEST: Which ones are we talking about?
MISS KOLIS: I am limiting myself to the right eye pain, the pain behind the right temple, and in the back of the head.
MR. BEST: I apologize. I

am not sure I understand what you are driving at

THE WITNESS: I don't either.

Q Initially I think you fairly answered the diagnoses that you made would not account for the complaints of pain that Mr. Andrews had regarding headaches behind the right eye, the right temple, and the back of the head on the right side?

A Correct.

Q You indicated that based on the introductory letter there had been a diagnosis of cluster headaches?

A. Correct.

Q. My question to you is: As you were performing your examination and taking a look at the entire picture of symptoms, was there something else in your mind that could have been the diagnosis that would have caused those symptoms?

A No.

Q Nothing else, okay

A Not those specific symptoms

Q Based upon your experience in doing what you do for I guess the past almost 30 years, what symptoms at presentation suggest a neoplasm in the nasosinal cavity to you, are there some clinical symptoms that suggest that diagnosis?

A. In the sinus cavity?
Q. Correct.
A. The symptoms, usually a bloody show is the first sign, bleeding from the nose, unilateral bleeding, blood stained mucous, progressive obstruction, a nasal obstruction getting progressively worse, usually a foul odor, cacosmia, which is a foul odor.

Pain is usually a late onset due to bony erosion, and the sinus becomes totally opacified, x-rays show an obvious mass.
Q. So if I heard you correctly, I am trying to listen and I don't have time to write when I'm listening, the clinical symptoms that would lead you to have a concern for that kind of neoplasm would be a bloody show in the mucous?
A. Yes.
Q. Unilateral in nature?
A. Yes.
Q. An odor?
A. Usually a foul odor.
Q. What about facial pain or swelling?
A. Facial pain and swelling is usually **a** late finding when there is marked involvement of the sinuses, an erosion of the bone.

Q. Those would be the things that you would customarily expect to see to raise your level of suspicion?
A. Showing up on the CAT scan, MRI scan, correct.
Q. You indicated you had a brief opportunity to read the Akron City records from the Summer of 1997; am I stating that correctly?
A. I reviewed it very quickly to see if they tried to reach me
Q The kind of cancer that Mr. Andrews was diagnosed with, and I know I am not going to pronounce this correctly, pterygopalatine -- am I saying that correctly?
A Pterygopalatine fossa tumor
Q In your 30 years of practice have you ever been involved with a patient where that was the diagnosis?
A. I never had a patient with t at type of tumor
Q. Would you know from having read literature, and I am speaking prior to the lawsuit, prior to actually ever having seen Mr. Andrews, would you know how that particular type of cancer presents?
A. No, ma'am.

Q. Fair enough. Doctor, would you know as we sit here today if a CAT scan had been performed in the mastoid area, as was suggested by Dr. Pepe, if that in fact is the region where the cancer was located at the time of diagnosis?

MR. VOUDOURIS: Objection. *Go* ahead.

A. Please repeat that question.

MISS KOLIS: Sure. Can you repeat it, Kris?

(Question read.)

MR. VOUDOURIS: Objection. *Go* ahead.

A. I am not an expert in reading or interpreting MRI's and CAT scans. I don't know if I would have known it or not.

Q. Fair enough. Doctor, during the examination or I guess at the conclusion of the examination, if I didn't misread the note that you prepared, you were attributing Mr. Andrews' ear pain to a bite problem; do I misinterpret that, or am I interpreting that correctly?

A. One of the most common causes of ear pain is

TMJ or a bite problem.
Q. So your answer to my question is in fact you were attributing his ear pain to his bite problem?
A. Yes.
Q. Was there anything else; well, the serous otitis media, you felt that contributed to his ear pain?
A. Serous otitis media is rarely associated with ear pain.
Q. What about sinusitis?
A. Sinusitis rarely causes ear pain, unless it's an acute infection of the ear.
Q. You didn't determine this to be an acute infection?
A. In mastoiditis an acute infection you would be bulging, red, and dull; his is the opposite of dull, glassy.
Q. There was not an acute infective process at that time?
A. Right, since mastoiditis was ruled out.
Q. Can a neoplasm such as was eventually found in Mr. Andrews be the cause of ear pain?
A. I do not know if that is the presenting compliant. I honestly don't know.
Q. Do you think he had TMJ, did you think that's

what he had, TMJ, and the reason I am asking, the way you wrote it in your return letter to Dr. Stringham was that he has a bite problem?

A. He was edentulous, he didn't have teeth, that leads to TMJ, and I believe in my physical examination, if we can refer back to that, he had increased popping and grading. TMJ, that usually indicates a TMJ problem. Most patients come to us with a complaint of ear pain with that finding.

Q. You told him to see his dentist?

A. Correct.

Q. Did you know who his dentist was?

A. No.

Q. Your recommendations as I read them, the pillows on his bed should be stuffed with Dacron?

A. Yes.

Q. Can you tell me why that is?

A. He was sleeping on feather filled pillows, that can cause allergies and sinus problems.

Q. Do you think he needed to be screened for allergies?

A. If he didn't get better with the medication. We recommend that we try conservative treatment first.

Q. He was to keep all pets and live plants out

of his bedroom?
A. He had a pet cat, and cats out *of* all furbearing animals cause most allergies.
Q. Do you know how long he had a cat?
A. No.
Q. He is obviously to discontinue smoking, that was to address what issues, general health of course, but anything that was contained to your diagnoses?
A. According to the history Mr. Andrews is a two pack a day smoker. People who smoke or even around smokers have up to six times more ear, nose, and throat problems than those who don't smoke.
Q. You were hoping discontinuation of smoking would show an improvement in his symptoms?
A. The sinus findings, as well as the fluid in his ears, correct.
Q. Referring to the beginning of this page it says this patient should discontinue his Beconase AQ and try Nasacort AQ at bedtime and Claritin in the morning?
A. Correct.
Q. First of all, were you aware at the time that you performed your physical and made these recommendations of all the medications he was on?

A. I believe you have that.
Q. That is the list?
A. Yes, ma'am.
Q. That is not your handwriting; is that your nurse's handwriting?
A. I don't know, it doesn't look like my nurse's either.
Q. The patient himself could have given that to you?
A. I just have a photocopy, not the original, that's why I assume he brought that with him.
Q. Why did you want him to try that particular combination of medications?
A. My experience is that that combination worked better than the medicine he was on.
Q. Which of those medications would have affected his serous otitis media?
A. Both.
Q. How would they have done that?
A. By decreasing swelling, congestion from what I thought were allergic problems.
Q. If taking those medications didn't cause a change in those symptoms, what would that have led you to conclude?
A. That he wasn't compliant with my other

recommendations.
Q. If you found out he was compliant and hadn't changed the symptoms, what would that lead you to conclude?
A. That there was probably another process going on, you look at the next level, other causes.
Q. What alternative process would it suggest to you when you refer to looking at another level?
MR. BEST: So the hypothetical is clear, tell him what symptoms, which ones didn't -- what did the patient do.
Q. I thought I premised this series of questions on the serous otitis media.
My question to you was if the patient was compliant with the medication regimen you put him on, how long would he have needed to be on it and be compliant with it before you would expect to see an improvement with the serous otitis media?
A. Four weeks is a fair trial, if he is compliant with the other recommendation.
Q. Is that why you asked him to come back in a month?
A. Correct.
Q. To give it a four week trial?

A. At least a four week trial.
Q. If in fact hypothetically he was compliant with the Nasacort and Claritin, as you indicated --
MR. BEST: And everything else?
MISS KOLIS: And everything else.
Q. Let me ask it this way: If he was compliant with the Nasacort and Claritin, slept with Dacron pillows, kept all his pets and plants out of his bedroom, but wasn't able to quit smoking, would you expect for him to have improvement on that regimen?
A. Possibly not.
Q. Because of the smoking?
A. Correct.
Q. But if there was no improvement whatsoever, even hypothetically assuming if he was able to do everything, you indicated it would make you think of something else and go to the next level; what would it make you think and what next level would you be contemplating?
A. As I mentioned in this letter I would have thought about his very large tonsils, and I would have thought to evaluate him under anesthesia, possibly remove his tonsils and adenoids, and put a

tube in his ear to alleviate the fluid present in his left ear -- correction, his right ear.

Q. Those were the things you were thinking?

A. Yes.

Q. I need to ask you a question: In your own handwriting here -- let me try to ask this intelligently.

Do you dictate your consultation notes?

A. Yes.

Q. Someone transcribes them for you?

A. Correct.

Q. Then you read them?

A. Yes.

Q. If everything you were thinking isn't in the note, do you add some things in handwriting?

A. Mental notes for the follow-up visit on my copy only.

Q. Because in this instance what I received obviously in your chart is in addition to the typewritten portion, there then appears some handwriting?

A. Correct.

Q. If you want to look at that, I can't make out the top two. I know what the third one is.

A It takes four years of medical school to write that bad.

Q. I haven't had that privilege

Tell me in order what those three handwritten -- I don't want to call them additions; when would you have put those on the paper?

A. I have it right here

Top one, question mark --

MS. BEST: The question is when would you have made the notes?

THE WITNESS: I apologize

MR. ASM: You're doing fine

Q. When would you have made those notes?

A I dictate at the end of each day so the work is fresh in my mind I dictate from the notes we have here filled out by both my assistant and myself We dictate that evening, usually it's transcribed within 24 hours I have read it, signed it, and get it mailed off

In the process of reading it there are mental notes that I want to check up with when the patient returns So probably when I read the transcribed report, after the patient was seen,

that's when these were done.
Q. Can you tell me what those say?
A. I put down here the mental notes to follow-up on, question mark, check sinus, see status if it was improving. Conservative therapy, plus or minus, septoplasty, possibility of doing possible septoplasty. Check the septum, question mark HIV.
Q. Just so I am clear about what you were thinking at that time, that looks like a question mark to me?
A. It is.
Q. Question sinus?
A. Question mark, check sinus.
Q. When he came back you wanted to recheck his sinuses?
A. I repeated the x-ray.
Q. Is that your Waters view?
A. Yes.
Q. Of what benefit of doing a Waters view x-ray in evaluating the sinuses?
A. This is our routine, my routine at the office, I see a patient with sinus problems, we get a baseline study, and we treat the problem conservatively. When they return we repeat the x-ray to see if it has improved, remained

unchanged, or got worse.
Q. Did you have some findings on your Waters x-ray?
A. Yes.
Q. What were those findings?
A. It appeared the patient had a possible mucous retention cyst of the maxillary sinus.
Q. What is a mucous retention cyst?
A. It consists of a blocked mucous gland, the lining of our sinuses, mucous membrane, and with infection and allergies it becomes blocked, fills up with trapped mucous, much like a balloon filled with water.
Q. What physical problems does it cause?
A. Rarely does it cause symptoms, it's an incidental finding. When you see it you think of allergies or infection.
Q. Anything else besides allergies and infections that can cause that retention cyst?
A. I can't think of anything else. Those are the most common causes.
Q. Then the next one is check --
A. Plus or minus, septoplasty.
Q. That is because he had a deviation in his septum?

A. Correct.

Q. Check septum, is that in conjunction with the septoplasty or for some other reason you wanted to check the septum?

A I was thinking of possibly at the time we were going to do a tonsillectomy, adenoidectomy, put a tube in his right ear, and was considering doing a septoplasty on this gentleman.

When he was going to come back to see me I was going to check the septum to determine the extent of the involvement, that's what that meant by check septum.

Q. Then you put question HIV; can I inquire why that was a consideration or concern for you?

A. At the time of examination this gentleman presented with very large tonsils. Tonsils and adenoids should get smaller, by age 12 they should disappear; and with enlarged tonsils, if there is a sudden increase in size of tonsils, that is one of the first signs of HIV, a of the heavy coating of the tongue is also suggestive of that

Q. Are enlarged tonsils and a coated tongue also found in the population of people who are heavy smokers?

A Coating of the tongue is, but I don't think

the enlarged tonsils are.
Q. That was a concern you had?
A. If the tonsils were larger, if the coating of the tongue was worse, then I would have evaluated him for HIV.
Q. That was going to be my next question.
You didn't send him for an HIV test?
A. I did not do that. I don't apply that label to patients off the bat.
Q. In your own mind you put question HIV, you were going to watch to see if his tonsils were more enlarged to you on the return visit?
A. I wanted to see if the antibiotic Biaxin was going to help him, and if the tonsils were larger and with the heavy coating of the tongue I would have evaluated him.
Q. I'm just asking if hypothetically he had returned to your office in one month and his tonsils were larger, would you at that point ask him to go for an HIV test?
A. Yes, ma'am.
Q. Did you at any time share those concerns with or express your thoughts with Dr. Stringham or Dr. Denton?

A. No, I did not.
Q. Can I conclude, and I might be in error, that these handwritten notes that you made, these three little or four, I thought there were three, but it's four indications in your handwriting, those didn't appear on the letter you sent to Dr. Stringham?
A. No, ma'am.
Q. Let's take a look at your physical examination, if you don't mind.
You did a hearing test on Mr. Andrews. Can you tell me what the purpose was in performing that hearing examination?
A. The decision to get an audiogram was based on my physical findings, and also the introductory letter from Dr. Stringham.
Q. I'm sorry. Were you done with your answer?
A. That's it.
Q. What in the introductory letter caused you to believe that an audiogram would be a good idea?
A. Dr. Stringham mentioned that there appeared to be a large posteroinferior perforation of the right eardrum.
Q. You wanted to evaluate that?
A. And confirm whether or not it was present.

Q. Was it present?
A. No.
Q. Do you have any idea why Dr. Stringham thought there was a perforation, and if you don't know, that's all right?
MR. VOUDOURIS: Objection.
A. I don't know.
Q. So you did that examination.
Your findings were, and I am going to generalize it, there was some hearing loss in both ears, correct?
A. Correct.
Q. Did you have any idea medically what the cause of the hearing loss was in the right ear?
A. Based on my findings due to a combination of nerve deafness from hypertension, cause undetermined, and the conductive component was due to the fluid in the ear.
Q. What about the left ear?
A. The left ear shows primarily a high frequency nerve loss, due to possible hypertension, circulatory changes, cause undetermined. There was some suggestion there might be otosclerosis based on the audiogram.
Q. Next, if you want to turn to your physical

examination sheet; is this a standard office form that you have that you actually complete during the physical examination?

A Both I and Dr. doctor's assistant complete this

Q. Did you have a doctor's assistant present with you when you performed the physical examination on Jack Andrews?

A Yes.

Q Do you know that because the writing is someone else's, at least on the top, or is the name listed somewhere?

A Whose initials

Q. Whose initials are those?

A Sandy Belts, we have two physician assistants, and Sandy was our that day

Q. Looking at your examination of the oral cavity and pharynx, if you could skip down close to the bottom, can I conclude you did not perform the examination of the pharynx?

A I tried to examine the nasopharynx but because of the size of the tonsils and his gagging because of being a smoker, I was unable to visualize that area.

Q. I meant a little higher, Number 3, where it

says pharynx versus nasopharynx. You have it listed as separate examinations.

There is no information contained in the examination of the pharynx, does that mean you did not elect to do that examination?

A. No, it was part of the tonsil examination, the pharynx includes tonsils, and they were very large and obstructed the view.

Q. You were not able to visualize completely, is that what you were stating?

A. 3 plus tonsils are almost kissing each other.

Q. What kind of examination could you have performed; what kind did you try to perform? Let's start with that.

A. Under oral cavity and pharynx, under teeth, edentulous, means he didn't have teeth. Oral cavity, heavy coating on tongue, tonsils 3 plus enlarged, large tonsils again being part of the pharynx.

TMJ, increased popping and grading. Nasopharynx, I put an X there because it wasn't done. Increased gagger due to smoking, and I had written smoker in parentheses.

Q. What kind of equipment do you have available in your office that will allow you to visualize the

nasopharynx in a person who is a bad gagger, bad gagger is not a very good medical term, but you are indicating he is a gagger?

A. He is a gagger.

Q. Were you using a mirror?

A. Yes. I use a mirror with most of my cases.

Q. Do you have equipment that would allow you to visualize those structures in a bad gagger?

A. Yes.

Q. What?

A. A flexible nasal throat scope.

Q. I don't see an indication that you used it, so would I be right that you did not try to do that?

A. I did not use that at that time based on the negative CT and MRI findings. I do not scope everybody when they first come to the office.

Q. You are saying you elected not to do that because the CT and the MRI were negative?

A. It reduced my level of suspicion.

Q. You just covered increased gagger, smoker, the next line says what?

A. That's the upright Waters view and the lateral view of the sinus we performed in the office as baseline studies, and it says MRC, my

abbreviation for mucous retention cyst.
Q. It looked like MRI to me.
A. MRC. Right antrum, which is the right maxillary sinus. Antrum is the medical term for maxillary sinus.
Q. Underneath it you wrote?
A. Reviewed MRI, parentheses, see reports.
Q. Do you want to turn to the back page for me?
A. Yes, ma'am.
Q. At the top it listed Number 4 on your examination list, I don't follow why that is that way -- I see, never mind.
You didn't do an examination of the neck?
A. No.
Q. You didn't feel it was indicated?
A. No.
Q. What structures are contained within the neck that could cause or contribute to ear or facial pain?
A. I can't think of anything right now in the neck.
Q. The next area is the face. When you write face on your physical examination sheets, it's there if you do an examination of the face, **I**

guess?
A. Correct.
Q. I know it sounds silly, but when you have face on your sheet, as an ENT what would you be examining?
A. Any paralysis, any asymmetry.
Q. You didn't test Mr. Andrews' cranial nerve function, did you?
A. No.
Q. Isn't that part of a routine examination for an ENT?
A. No, it's not.
Q. What instance would you perform a cranial nerve examination?
A. The only cranial nerve exam is the hearing aspect.
Q. That is the only one you do?
A. When patients present with their problems.
Q. What about eyes, what does that mean?
A. The eyes were examined, if indeed they have diplopia, any visual complaints, and there was none of that that I can recall.
Q. Then the vestibular examination I think we just covered, you didn't get into that area; am I right?

A. This area is reserved for those who present with dizziness or vertigo.

Q. I am guessing, when I have you read impressions, it's what you put in your report, for purposes of clarity would you mind reading into the record your handwritten impressions of this particular patient?

MR. BEST: She wants it exactly what you wrote; don't editorialize, read it.

A. Ear pain, the arrow points to my rule out TMJ. Enlarged tonsils, the double arrow up means enlarged tonsils, coated tongue. My mental note for me to think about when I saw the patient again, plus or minus, HIV question mark.

Number 2, right serous otitis media, that's SOM. MRC, right mucous retention cyst. DNS is my abbreviation for deviated nasal septum. Headaches, clustered by history, meaning that is the history I got from Dr. Denton.

MR. BEST: She just wants you to read it. She just wants to know what you wrote down. She may have questions about it, just read it.

A. Those are my working diagnoses or

impressions.

Q. Then your recommendations, I really suspect it's exactly what's in there, but if you don't mind reading it for me.

A. DC Nasacort AQ, Q.h.s; Claritin, q. a.m. RTO, return to office, one month. No change. M/C, TNA. plus right tympanotomy and tube. MT. Plus or minus septoplasty Question mark, rule out HIV, check sinus. see dentist Dacron pillows, no pets, live plants in bedroom. DC smoking, and then question mark, hearing aid evaluation, HAE, hearing aid evaluation, and fitting, fitting of the hearing aid

Q 10-10-96?

A See notes, refers to the phone call

Q. Let's go to the phone call notes, before we do that, let me ask you: You forwarded the report to Dr. Stringham on behalf of Dr. Denton, I guess that's the way the request was written, did you assume that the patient was going to continue to see the internal medicine doctors?

A That was my suggestion yes

Q Your understanding was that he was being seen by you strictly in consultation?

A. Correct.
Q. To amplify or clarify diagnoses?
A. To evaluate the patient for subacute mastoiditis.
Q. You did ask the patient to come back?
A. Yes.
Q. If I am reading the chart correctly, that visit was scheduled for sometime October 24th, I believe?
A. A month later.
Q. Prior to that scheduled office visit, your office received a phone call from Mr. Andrews; is that accurate?
A. Correct.
Q. Those are the yellow sticky notes in the back, is that the way your office keeps phone messages?
A. Yes.
Q. Can I gather the handwriting -- you can look in your own if you want to -- the handwriting, is that a nurse's handwriting, she is taking the information?
A. No, this is my secretary.
Q. So your secretary takes the phone calls, lists the complaints, and then communicates them to

you or shows you the piece of paper; is that how it works in your office?

A. Routinely when the patient calls the office the secretary takes the message, writes it down, retrieves the chart, places a sticky note on the chart for me to look at. She does not bring it to me directly as the call comes in, it's stacked up on my desk.

Q. You are probably seeing patients at that point?

A. Correct.

Q. From your review of those notes and your own independent recollection during this phone call, and what I am assuming was a phone call for information, did you speak with the patient or did your secretary?

A. I had no direct contact with the patient, it was all handled by my secretary.

Q. I am going to read this, if I read anything wrong you tell me, just to make sure I understand it. It says Jack Andrews, and it his phone number, saw you 9-26. Return office visit, 10-24, had severe pain in head times four months.

You were aware based on the

period of at least three months?
A. Attributed to cluster headaches, yes, ma'am.
Q. You and I think that is Rx, probably, Claritin, Nasacort, et cetera.
It says over, do you see where it says over at the end; is that your handwriting?
A. My writing.
Q. We will come back to that, has gone through three bottles of Tylenol. Patient says he can't take anymore pain. Severe pain in right side from right eye up over temple, down behind ear and around to the jawbone, wants something for pain; am I have reading this sequentially?
A. Yes.
MR. VOUDOURIS: I think it says two bottles of Tylenol.
MISS KOLIS: Make sure it's two bottles.
Q. Wants something for pain, or to find out why he has pain, and then underneath it it says Rx; is that your prescription number?
A. That is the drugstore number, pharmacy number.
Q. He has already tried Imitrex, Seldane --
A. You left out allergic to Penicillin.

Q What is hi[illegible]n there?
A Yes. He told my secretary he was allergic to Penicillin.
Q. He has already tried Amitrex, Seldane, Suprax, Calan SR, Maroxaset, Sansert, sulfa, trimeth, cioxin, Glyatex; is that Ultram?
A Yes, ma'am.
Q Claritin, Beconase, Nasacort A[illegible]: was that the end of that phone message?
A Correct.
Q Do you believe she gave it to you the same day?
A. Yes, ma'am, to the best of my recollection.
Q There are two phone calls that day, right?
A Yes, to the best of my recollection there is a Number two.
Q Let's deal with Number 1 At some point -- you have no way of knowing what time of day you got these phone calls, but at time you were able to look at the note; is that an accurate statement?
A I don't know what day of the week this 10th of October, '9[illegible] was
MR BEST: She wants to know what time. If you don't know, that's okay.
Q. It's okay.

A I don't know.

Q. Do you believe it was that same day you were able to read this note and make your own notes?

A. Based on what I have here, yes, it must have been the same day.

Q. Now, your writing is kind of small, but can we go through your comments relative to the information reported, okay?

MR. BEST: Same thing, she wants you to read your notes. She wants to make sure she understands the record.

A. I understand. Starting at the top there, okay to see sooner or keep this appointment, meaning 10-20, the one he had scheduled.

Reference pain, that is REF. I still think it's due to -- and I circled the jawbone part, I am talking about the jawbone pain, and the arrow going down to the jawbone. I still think it's due to his bite problem, must see dentist for dentures, and then I wrote "over". I prescribed Darvocet-N 100.

Q. I see. Now I see why it says "over," because this is the back of this?

A. Correct. I'm sorry about that.

Q That's all right.

A. Darvocet-N 100, dispense 50 tablets, sig, means take one every four to six hours for pain, plus local heat to right ear area. Okay, then an arrow down there, tell patient will repeat CT scan, ear and sinus. Signs and symptoms remain unchanged, return to office to recheck.

Q. I have a couple questions about the information we have been through.

It says I still think it's due to his bite, and preceding that was REF. You are saying or your impressions were that this pain on the right side from the right eye up over the temple is pain, reference pain from the jaw?

A. No, I meant that the jaw pain, he said it came around to the jawbone, I circled jawbone, reference pain of the jawbone. I still think it's due to a bite problem, must see dentist for dentures.

Q. You weren't implying that you thought the other pain was referred pain from the jawbone?

A. No, I thought it was his cluster headaches.

Q. So reference is just reference to you drawing a line and circling the word jawbone?

A. Yes.

Q. Now, you gave him some Darvocet which you had

not prescribed at that first encounter, correct?
A. Correct.
Q. Did you interpret the information which he gave to your secretary to indicate that he had an increase in pain, or that the pain was the same pain that you had seen him with on the 26th, but thinks what he was taking was ineffective to manage it?
A. I don't understand that question.
Q. You prescribed Darvocet, you had not done that at the first examination; we are in agreement with that?
A. Yes.
Q. You prescribed Darvocet for pain I gather, right?
A. Correct, for TMJ pain.
Q. Did you think this was a new onset or increase of pain from the time you had seen him on the 26th? I am just asking you if you know what you thought.
A. I didn't think it was a new pain. I wanted to address the TMJ problem.
Q. You didn't prescribe anything to address pain at the first physical examination of him?
A. He was sent to me for mastoiditis, I didn't

look into the pain aspect of it.

Q. When he was calling with increased complaints of pain, did it occur to you to have him call internal medicine to discuss the pain issue?

A. I assumed that he was followed by Dr. Stringham. I was not treating him for cluster headaches. I do not treat cluster headaches.

Q. I am confusing the issue by not asking the appropriate question.

You said you were seeing him not for the cluster headaches, you weren't treating that. I'm asking why you elected to prescribe pain medication for him without consulting with internal medicine first?

A. I was treating the jaw pain, which I thought was TMJ, and I thought the Darvocet would be adequate for that.

Q. I accept your explanation.

I think you read this to me, but I didn't catch it, to the right-hand side where it says Darvocet, it looks like you prescribed 50 -- what is that?

A. Darvocet-N 100 is the name of the medication, dispense 50 tablets, sig, take one every six hours -- correction, q. four to six hours.

Q. Fair enough.
A. Every four to six hours for pain.
Q. Now, you indicate that the bottom line says tell patient will repeat CAT scan, ear and sinus.
When you wrote your consult letter to Dr. Denton you didn't indicate you were contemplating a CAT scan of the ear and sinus, did you?
A. I did not indicate that because at that time he had essentially negative results, the reports on his previous scans, he had two sets of scans.
Q. Why on October 10th did you want your secretary to tell Mr. Andrews that you would repeat the CAT scan of the ear and sinus?
A. If he wasn't getting better we always repeat it. If the patient is not getting better, if symptoms persist, if he doesn't respond to conservative therapy, we go back and re-evaluate at a different level.
Q. Apparently, and I am saying apparently because I can only conclude certain things, your secretary must have called Mr. Andrews and shared both your comments to him?
A. It's on the left upper hand corner, up here.
Q. Where it says call patient?

A. JR is Joyce Ridgeway.
Q. I was guessing she did because there are more notes, but that clarifies that.
Your secretary, is she instructed to relate to the patient each and every piece of information that you add around the note; do you know what question I am asking?
A. No, ma'am.
Q. Your secretary is not a physician, correct?
A. She is not.
Q. Is she a nurse?
A. No.
Q. How does she know what information to communicate to the patient based upon your note?
A. She has been instructed to convey what we have written.
Q. That was my question, I didn't ask it very well.
Would she say hi, Mr. Andrews -- what did you say her name was?
A. Joyce.
Q. -- the doctor says it's okay for you to keep your appointment as scheduled, if you want to come in sooner, fine. He thinks what you are experiencing is due to your jaw pain. Do you see

my problem? I'm trying to figure out how I know -- and I could probably take her deposition -- how I know exactly what she told the patient.

A. I have no idea. I assume she gave him all the information. She is very good about it. I have not had anybody complain of a lack of transmitting information.

Q. She gave him the information?

A. Correct.

Q. Then it has Jack Andrews number two?

A. Correct.

Q. It says patient says he does not agree. When he was in ER he was told he had two holes in his right eardrum. Dr. Denton told him he has fluid in his right mastoid. Patient says he has no hearing in his right ear. He doesn't think these are related to TMJ.

Do you get the impression from this note, and I'm just asking you what impressions as a doctor you get, because this is how your office is communicating to you, that Mr. Andrews understood your secretary to have told him his right-sided pain, his right ear pain was caused by the jaw?

A. I don't know how she could have come to that conclusion.

Q. This is pretty clearly in her writing what the patient's response is to the information he was given; do you agree with that?
A. He seems to be questioning my findings. I interpret this as questioning my findings. He doesn't agree with me, and in talking about his ear, he was told he has two holes in his eardrum, which we showed with our testing he did not have.

Dr. Denton said he had fluid in his right mastoid, yes, he agreed to that. He had significant hearing loss, but where he related that to the TMJ, I have no idea how he got that concept.

We were talking about jaw pain in the first call, I was treating that. That was due to his bite, and I don't know how he got any other conclusion, and if he did conclude that he should have come in to talk about it.
Q. You had the opportunity to read a note written by Joyce. She stated patient -- he doesn't think these things are related to TMJ?
A. Correct.
Q. Did you attempt to call Mr. Andrews yourself after this second message from the patient?
A. No, I did not.

Q. I really had trouble reading this one, could you read into the record what your note to your secretary was following Mr. Andrews' comments that he didn't think that his complaints were related *to* his TMJ?

A. Agree his hearing loss in right ear is due to fluid in his mastoid. He does not have two holes in right eardrum, if he did the fluid would drain out and we would see the drainage.

Fluid in mastoid does not usually cause the pain he claims he has, that pain is TMJ until proven otherwise.

To get hearing back in right ear requires putting a hole in his eardrum to drain out the fluid, this can be done in our office if needed at his return office visit appointment, or in surgery with his TNA and possible septoplasty.

Q. It says called patient, JR again, she would have called him and relayed those impressions?

A. Correct.

Q. I want to ask you about this: You wrote fluid in mastoid does not usually cause the pain he claims to have. Would you agree with me on the day he called in he was complaining about more than pain in his ear?

A. He was having symptoms that sounded like cluster headaches.
Q. Those were right-sided facial pain from the eye up over the temple down from the ear to the jawbone?
A. Right.
Q. Dr. Milo, October 24th, 1996 came and went, Mr. Andrews did not come to your office?
A. Correct.
Q. What is your office's procedure regarding a no-show on a patient?
A. If it's a post-op patient we call and ask why they didn't keep their post-op visit; nonsurgical patients we do not call or follow-up.
Q. Since you have written to Dr. Stringham for Dr. Denton, I keep saying it that way, that is the way the letter came, would it be your policy to write a letter to the referring doctor indicating their patient had not shown up for their follow-up visit?
A. No, it's not our policy unless it's a post-op patient, then we will question that.
Q. In as much as the 10-10-96 telephone communication indicates that you were going to do a repeat CT of the ear and sinus, did you think you

should have written them a letter indicating you believe he probably needed one?
A. No.
Q. It's clear to you, and this is probably going to sound silly, when you indicated in that sentence there would be a repeat CT of the ear and sinus, in fact the ear and sinus had not been CT'd; is that an accurate statement?
A. They were included in the scans.
Q. He had comments on the sinus, and the mastoid in his MRI scan?
A. Dr. Pepe made it in his report.
Q. I just have a couple more.
Dr. Milo, have you ever served as an expert of a doctor in a medical negligence case?
A. Once.
Q. When was that?
A. Approximately three years ago.
Q. Was that in Summit County?
A. Yes, ma'am.
Q. Who was the doctor that you were opining for I guess is the word; do you remember?
A. I believe it was a Dr. Ciraldo, general surgeon.
Q. Fair enough.

Do you remember the plaintiff's attorney in that case?

A. No, I do not.

Q. When did you find out that Mr. Andrews was diagnosed with cancer?

A. I honestly don't remember the date. Shortly after the 180 day letter I got.

Q. Is it okay for me to assume after he was diagnosed and being treated at Akron City, no one from Akron Internal Medicine -- is that what they are called, I am not sure -- the internal medicine practice, Dr. Denton, no one called you to discuss this case?

A. No one called.

Q. You didn't know about it until you received a letter from myself?

A. Yes, correct.

MISS KOLIS: 1 appreciate your time and cooperation you have given. I do not have any other questions.

THE WITNESS: Thank you.

MR. BEST: He is entitled to ask some questions. I think he is thinking whether he needs to or not. We will hang on for a second.

MR. VOUDOURIS: Doctor, we met before. My name is Peter Voudouris. I am here on behalf of Summa Health Systems and Dr. Denton.

CROSS-EXAMINATION

BY MR. VOUDOURIS:

Q. As I understood your testimony, since you are not an expert in the field of radiology, you relied on the interpretations by Dr. Pepe and the other radiologists who interpreted the CT scan?

A. That is correct.

Q. Is it fair to assume that the residents had a right to rely at least on your physical exam, and your findings that you performed in September, '96 on this patient?

A. Yes.

MR. VOUDOURIS: That's all I have. Thank you.

MISS KOLIS: Doctor, I am going to have today's testimony transcribed. You do have the right to read it. I assume your attorney would like you to.

I will waive the seven day reading requirement. I don't need to see it within seven days if I can secure your agreement within

30 days?

THE WITNESS: Yes, ma'am.

(Deposition concluded; signature not waived.)

ERRATA SHEET

NOTATION	PAGE/LINE

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

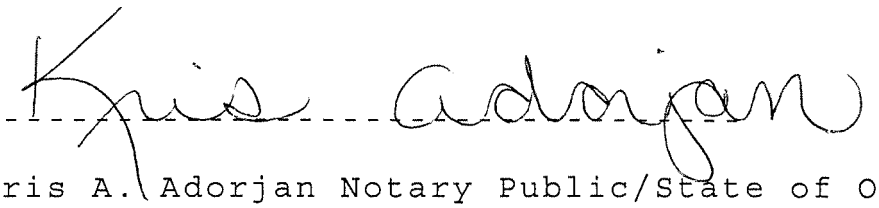
.....

ANTON P. MILO, M.D.

The State of Ohio,
County of Cuyahoga. CERTIFICATE:

I, Kris A. Adorjan, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, ANTON P. MILO, M.D., was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid. I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 1ST day of APRIL, 1999.



Kris A. Adorjan Notary Public/State of Ohio.
Commission expiration: 11-30-02.

Look-See Concordance Report

UNIQUE WORDS: **1,156**
TOTAL OCCURRENCES: **3,365**
NOISE WORDS: **384**
TOTAL WORDS IN FILE: **10,209**

SINGLE FILE CONCORDANCE

CASE SENSITIVE

COVER PAGES = 4

INCLUDES ALL TEXT OCCURRENCES

DATES **ON**

INCLUDES PURE NUMBERS

POSSESSIVE FORMS ON

MAXIMUM TRACKED OCCURRENCE THRESHOLD: 50

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

LIST OF THRESHOLD WORDS:

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4-396: Jack Andrews

Deposition of
Anton Milo, M.D.

Friday, March 26,1999

No Exhibits marked

FAGE / LINE	**DESCRIPTION**
Prior Litigation	
5 15-19	Has previously given a deposition in medical/legal litigation; Mas been previously sued for medical negligence; Once before; Summit County; Was found innocent; Case went to trial
6 / 6	Brought his office chart with him
Request for backside of examination page made	
Review of Curriculum Vitae	
7 / 11-25	*Attended OSU; graduated in 1960 *Did internship in Hawaii while in the army *Went directly into the army after medical school *Did pre-specialty surgical training at Fort Dix *Did ENT residency in 1965 at Walter Reed
8 / 3-17	*Served as Director of the Army Hearing & Speech Center *Post-grad study in audiology *When coming to Akron, practiced ENT and head & neck surgery *Presently is a surgeon "Boarded in otolaryngology in 1967, when he completed his residency
918	Not boarded in surgery, just otolaryngology and head & neck surgery
9 / 12	Performs benign and malignant tumor surgery of the head & neck
91 16	Had a private practice in 1970 as a solo surgeon
9/20	Was affiliated with Akron City, St. Thomas, Children's Hosp of Akron, AGMC
1012	Still has privileges at same facilities
10 / 5	Performs majority of surgeries at Akron City, nka Summa Health Systems, and Children's

REVIEW OF OFFICE NOTES

10115	Has review the medical records in addition to his office chart
10148-21	St. Thomas records of 12196, Akron City records of 7/97
11 / 6	Initially saw Jack upon the referral of Dr. Stringham

Letter of 9/10/96 – Patient referral/MR & CT films

11116	Did not speak with Dr. Denton or Stringham prior to seeing Jack
12117	Believed letter was that of introduction that covered the patient's Hx; he was to answer or work on the patient's subacute mastoiditis
12119	Made him think diagnosis of S/M was uncertain and expert input was needed
13 / 3	Small handwriting is most likely Dr. Milo's
13110-15	Did not receive scan reports with the letter; asked secretary to request it; after reviewing report, wanted patient to bring films to appointment
13118	Wanted to quantify the radiologist's report
14 / 1	Wanted to see lie saw on the films what the report stated as the radiologist's impression
14111-14	Admits to not be an expert on reading MR/CT films; just strictly wanted to see if he could see on the film what was reported
14119	Pathology referred to are Impressions 2 & 3
14-25115-3	Wanted to quantify the word moderate and the cause of the swelling of the lining of the sinus; it could be from allergies or sinus infection
15 7-10	Assumed is was generalized swelling because there was no mention of a tumor or malignancy
15 / 15	The MRI does show the area of the sinuses, enough to make comment to the effect if there were a tumor in the nasosinal cavity
15/ 19	Knows Dr. Pepe very well (radiologist)
16115	Dr. Pepe suggested in his report that CT of the temporal bone; impression stated there was not a recent CT and revealed sclerosis suggesting chronic changes; assumed it was sufficient
16/ 19	CT performed (before the MR) did not specify the mastoid region

16/21 CT was one of the head

16/25 Had no comment on the CT

17 / 3 He was concerned with the secondary finding of fluid in the mastoid region representing an inflammatory process

17 / 13 Fluid in the mastoid region could be caused by a neoplasm

REVIEW OF CONSULT REPORT

181 14 Milo's diagnosis was seroud otitis media (fluid in the middle ear), not subacute mastoiditis

18/ 19-21 Sinusitis many times causes fluid in the ears

1918 None of his findings are the cause of the type of pain experience by the patient

19 / 14 Agrees with Stringham's letter that the pain was caused by cluster headaches

20 / 8 The diagnoses lie made does not answer for the type of pain Mr. Andrew's experienced behind his right eye and temple.. ..

20 / 18 There was nothing else he thought of that would be the cause of Mr. Andrew's pain

SIGNS/SYMPTOMS of Neoplasm in the sinus cavity

21 / 3-11 Bloody show at first, bleeding from the nose, unilateral bleeding, blood stained mucous, progressive obstruction, nasal obstruction that is getting worse, a foul odor, cacosmia – a foul odor; pain is usually late onset and the sinus becomes totally opacified, x-rays show an obvious mass

21 / 23 Facial pain and swelling develops later when there is marked involvement and erosion of the bone

REVIEW OF Summer of 1997 AKRON CITY Records

22/15 Type of cancer Jack was diagnosed with is pterygopalatine fossa tumor

221 19 Never had a patient with that diagnosis

22 / 25 Had never reviewed any literature on this type of cancer prior to seeing Mr. Andrews

23 / 16 Is not an expert in reading/interpreting films, cannot say if diagnosis would have been made if CT of the mastoid area had been done

23-25/24-1 One of the most common causes of ear pain is TMJ or a bite problem

24 / 4	Therefore, he attributed Jack's pain to a bite problem
24 / 11	Sinusitis rarely causes ear pain unless it's an acute ear infection
241 15	Jack was the had opposite signs of having an acute infection
24 / 23	Didn't know if ear pain was a presenting Complaint
25 / 4-9	Because Jack had popping and grading, thought it indicated a TMJ problem
25 / 11	Told Jack to see his dentist
25 / 16	Suggested Jack to stuff his pillow with Dacron
251 18	Because feathered pillows, as Jack had, causes allergies and sinusitis
25 122	Would have recoininended being tested for allergies if Jack didn't get better; otherwise conservative treatment is followed
2612	Told Jack to keep pets, furbearing animals and live plants out of bedroom
26 / 10-13	Smokers and being around smokers causes up to **6** times more ear, nose and throat problems
26 122	Prescribed Beconase AQ and Nasacort AQ at bedtime and Claritin in the mornings
271 1	Was aware of medications Jack was on
27 / 14	Medicines Milo prescribed was because his experience was that the combination worked better than what he was already on
27 / 18-21	Both medicines would have affected serous otitis media by decreasing swelling, congestion caused by allergic problems
27 / 25	If no change, felt he may have been non-compliant
28 / 5	If found to be compliant, that one would look at the next level
28 I2 0	It would be approximately 4 weeks before any change would occur
28 / 24	That is for the reason for the one inonth follow up
13 113	Might not see change if Jack followed all instructions except quitting smoking
29-22/30-2	If no improvement, would have wanted to perform a TandA and place tube in ear for drainage
30 / 17	May add notes on his copy for the flu visit if not dictated

31 116 Dictates his notes at the end of each day from his and his assistant's notes; the notes are transcribed within 24 hours; handwritten notes are made after seeing the patient and final transcription

32 / 3 3 handwritten comments are mental follow-ups, ?, check sinus, see status if it was improving. Conservative therapy, +/-, septoplasty, possibility of doing possible septoplasty. Check septum, ? HIV

32121 Routine consists of getting a baseline study, treating the problem conservatively; upon return, a repeat x-ray is done to determine improvement or not

33 / 4 Had findings on Waters x-ray

3316 Appearance of possible mucous retention cyst of the maxillary sinus

33 19-13 A bloclted mucous gland

33 115 Rarely causes any problems; incidental finding

34 / 1 +/-, septoplasty was because Jack had a deviated septum

34 I 5-8 Was thinking of doing a septoplasty when doing the TandA and tube insertion

34 I 9-12 At Jack's follow up, wanted to see how involved the septum was

34 I 15-21 Enlarged tonsils and a heavy coating of the tongue is one of the first signs of HIV

35 I 14 Wouldn't have prescribed Biaxin on Jack's return visit if tonsils were larger

35 122 Would have also asked him to be tested for HIV

361 1 Did not share those concerns with Dentoii or Stringham

REVIEW OF PHYSICAL EXAM

361 14 The audiogram was because of Stringham's letter and Milo's physical findings

36 121 Stringham mentioned a large posteroinferior perforation of the right eardrum

3713 Same was not present

371 12 Diagnosed some hearing loss in both ears

37 I 15-18 Loss in right ear was medically caused by nerve deafness from hypertension, and the conductive component due to fluid in the ear

37 / 20-24 Loss in left ear possible due to hypertension, circulatory changes and some suggestion of otosclerosis

3819 His assistant was present at Jack's exam

38 / 15 Sandy Belts was the PA that day

38 / 21-24 Couldn't perform an exam of the nasopharynx because of enlarged tonsils and Jack's gagging

3916 The enlarged tonsils obstructed the view of the pharynx

39 / 15-19 Listing of exams performed: under oral cavity & pharynx, under teeth, edentulous; oral cavity, heavy coating on tongue, tonsils 3 plus enlarged

39 / 20-23 TMJ, increased popping and grading; nasopharynx (X means it wasn't done); increased gagger due to smoking

40 / 6 Was using a mirror to perform the exam

401 11 Has a flexible nasal throat scope to examine gaggers

40/ 15 Elected not to use it because of the CT & MRI findings; he doesn't scope everyone at the first visit

41 / 15 Did not examine Jack's neck

4216 When examining the face as an ENT, looking for paralysis, any asymmetry

42 / 12 Exams of the cranial nerve are not part of an ENT's exam

43 / 11-15 Hand written impressions: Ear pain, the arrow points to my rule out TMJ. Enlarged tonsils, double arrow up means enlarged tonsils, coated tongue. My mental note for me to think about when I saw the patient again, plus or minus, HIV?

43 / 16-20 Number 2, right serous otitis media, that's SOM. MRC, right mucous retention cyst. DNS is my abbreviation for deviated nasal septum. Headaches, clustered by history, meaning that is the history I got froin Dr. Denton

4415 Reading of his recommendations

REVIEW OF THE PHONE CALL NOTES

44 / 23 Suggested patient continue seeing internal medicine doctors

45 / 6 Did ask patient to return although it was only a consultation

45 / 10 Follow up was scheduled for 10124, one month later

46 / 3-8	When patients call, the secretary writes message on a yellow stickey, puts it on the chart, and stacks the chart on Milo's desk
46 / 17	Had no direct contact with Jack after initial visit; secretary handled everything
461 19	Reading of phone message into record
48 / 15	Jack had made 2 phone calls that day asking for soniething to relieve the pain
4914	Thinks he saw the phone messages the same day
49 / 12-21	Reading of notes responding to phone messages
50 / 1-6	Continued reading of response to phone messages
50 / 14-18	Still felt jaw pain was froin jawbone (bite problem); Jack should see dentist for dentures
50 / 21	Thought other pain was from cluster headaches
51 / 2	Prescribed him Darvocet that was not prescribed at first encounter
51 / 16	Prescribed Darvocet for TMJ pain
51 / 21	Was addressing the TMJ problem
51 / 25	Didn't look at the pain issue during first visit – only mastoiditis
52 / *5-7*	Assumed he was being followed by Dr. Stringham for the pain aspect/cluster headaches
52 / 15	Prescribed him Darvocet for the jaw pain (TMJ problem)
52 / 23	Prescribed Darvocet-N 100 for Jack to take every 4 – 6 hours
53 / 9-11	Didn't put in consult letter to Denton of contemplating a CT scan of the ear and sinus because previous reports were negative
53 115-19	On 10/10 wanted Jack to lsnow that; if/because patient doesn't get better, they always repeat
5418	Secretary is not instructed to relay each and every piece of information
54 / 15	She coiiveys only what is written
55 14-7	Can only assume she relayed all the information

56 14-8 Jack seemed to be responding to what secretary told him by questioning Milo's findings; didn't think pain was related to TMJ

56 125 Did not attempt to call patient himself

57 / 6-17 Reading of Milo's response to Jack's comments to secretary

581 1 Feels patient was calling with pain symptoms sounding like cluster headaches

5819 Jack did not attend the follow up appointment on 10/26/96

58 112 Calls are made to post-op patients only regarding not making appointments – not non-surgical patients

58/21 Does not write a letter to the referring physician about the patient's no-show

59 / 16 Served as an expert once

59 / 18-20 About 3 years ago in Summit County

59 / 23 It was for Dr. Ciraldo, a general surgeon

6016 Found out Jack had cancer after he received the 180-day letter

CROSS-EXAM BY PETER VOUDOURIS

61 / 11 Relied on interpretations of CTs & MRIs by Dr. Pepe and other radiologists

61 / 16 It's fair that the residents had a right to rely on Milo's consult report