

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

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IN THE COURT OF COMMON PLEAS  
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JACK ANDREWS, et al.,  
plaintiffs,

vs. : Case No. CV 98 124723

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

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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.

## FLOWERS, VERSAGI & CAMPELL



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APPEARANCES:

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NO EXHIBITS MARKED

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(FOR COMPLETE INDEX, SEE APPENDIX)(IF ASCII DISK ORDERED, SEE BACK COVER)

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1                                    ANTON P. MILO, M.D.

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

7                                    -----

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

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

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

21                                   THE WITNESS:                    Yes.

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

1

CROSS-EXAMINATION

2

BY MISS KOEIS:

3

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

4

5

A Yes I have

6

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

7

8

A Yes, it was

9

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

10

11

A Yes I have

12

Q Do you know approximately how many times?

13

A Once.

14

Q Was that also in Summit County?

15

A Yes

16

Q How did that litigation terminate?

17

A. I was found innocent.

18

Q Did that case actually go to trial?

19

A Yes, it did

20

Q Fair enough Doctor, prior to your filing a  
lawsuit, as you may recall from looking at your

21

22

chart, I requested that you send me your office

23

records, and those did come to me through Records

24

Department Service; do you recall having your

25

office assemble those records?

1 A. It's been a while.

2 Q. You probably didn't put them together  
3 yourself?

4 A. No.

5 Q. Did you bring with you your office chart?

6 A. I did.

7 Q. May I take a quick look at it?

8 MR. BEST: Let me take a  
9 quick look before you do that. I didn't get a  
10 chance to do that.

11 MISS KOLIS: Do you have a  
12 copier, David?

13 MR. BEST: Yes.

14 MISS KOLIS: Apparently when  
15 your office photocopied this they forgot to copy  
16 the back side of the examination page. I don't  
17 have that one, that one is not in my chart. It's  
18 not a big deal.

19 MR. BEST: Let's make sure  
20 what page we are talking about.

21 MISS KOLIS: The back side,  
22 that's the page I don't have.

23 Q. In the records which were supplied to me,  
24 which we are going to talk a little bit about  
25 today, there were pages that looked like office

1 telephone notes?

2 A. Yes, ma'am. It's in the back, ma'am.

3 Q. Oh, the yellow stickies. Thank you.

4 Mr. Best obviously will supply me with the  
5 secondary page.

6 This morning I was provided with a  
7 copy of your curriculum vitae. I want to briefly  
8 go over it.

9 It appears you graduated from  
10 medical school from Ohio State University?

11 A. Correct.

12 Q. About 1960?

13 A. Correct.

14 Q. You did an internship in Hawaii?

15 A. Yes, in the Army.

16 Q. That's how you got the privilege of going to  
17 Hawaii, you were in the Service?

18 A. I went directly into the Army after medical  
19 school.

20 Q. You did your pre-specialty surgical training  
21 at another Army facility, Fort Dix?

22 A. Yes, New Jersey.

23 Q. Then you did your ENT residency which you  
24 completed in 1965 at Walter Reed?

25 A. Correct.

1 Q. Then you served as director of the Army  
2 Hearing & Speech Center?

3 A. Correct.

4 Q. You did further postgraduate studies in  
5 audiology?

6 A. Correct.

7 Q. You came to Akron in 1970?

8 A. Yes.

9 Q. When you came to Akron what kind of practice  
10 did you go into?

11 A. Ear, nose and throat, and head, neck surgery.

12 Q. Are you a surgeon, Doctor, at present?

13 A. Yes, I am.

14 Q. When were you certified in otolaryngology,  
15 which I can hardly ever pronounce, is that 1965?

16 A. That's when I completed my residency. I took  
17 the Boards in 1967.

18 MR. BEST: Peter, do you  
19 have this page?

20 MR. VOUDOURIS: Actually, I  
21 think I do.

22 MR. BEST: I thought  
23 everybody did.

24 MR. VOUDOURIS: I think Records  
25 Deposition Bates stamped it as 4.



1                               MISS KOLIS:                   It's possible.

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

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

6                               THE WITNESS:               Yes.

7 Q.       Doctor, are you Boarded in surgery?

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

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

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

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

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

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

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

23 Q.       Has that remained the same through the years?

24 A.       Yes.

25 Q.       So you still have privileges at all of the

1 same facilities?

2 A. Yes, ma'am.

3 Q Where is the majority of the surgery that you  
4 perform conducted?

5 A Most of it is in Akron City ~~X~~ospital, now  
6 called Sum Health Systems, and Children's  
7 Hospital Medical Center.

8 Q Doctor, what I want to do is go over the  
9 office notes you prepared on r. Andrews

10 In preparation for today's  
11 deposition did you have an opportunity to review  
12 any medical records?

13 A. Besides mine?

14 Q. Right.

15 A. Yes, I have.

16 Q What records have you actually reviewed to  
17 the best of your recollection?

18 A The patient's Saint Thomas Hospital records  
19 of December, '96, and his Akron City ~~X~~ospital  
20 records of I believe July, '97 A quick review was  
21 performed on those records

22 Q When of course you had an opportunity to look  
23 at your own chart?

24 A. Correct.

25 Q. Is at any time I ask you a question and you

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

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

6       A.       Correct.

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

10      A.       Yes, ma'am.

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

16      A.       No, I did not.

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

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

25      Q.       I am not asking you to get into someone

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

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

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

14     A.       Yes, paragraph Number 3.

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

19     A.       The word questionable makes me think that.

20     Q.       Just so I can get oriented, although there is  
21     not that many handwritings in the chart, the little  
22     handwriting on the top indicating have patient  
23     bring in CT and MR with him for his office visit on  
24     9-26; is that your handwriting?

25     A.       Yes.

1 Q. Any time I see writing that looks like this  
2 that's probably you?

3 A. Correct.

4 Q. So you wanted the patient to bring in this CT  
5 and MR, and from review of your chart the patient  
6 did do that, didn't he?

7 A. This note at the bottom preceded that in the  
8 time sequence; can we go there?

9 Q. Absolutely.

10 A. I got the letter and there was no report,  
11 scan report, so I asked Joyce who was my secretary  
12 at that time to send for the copy of the MRI scan,  
13 and they faxed it to me. Then after reading that  
14 the next day I made the note to have the patient  
15 bring the films with him at that appointment.

16 Q. Why did you want the patient to bring the  
17 films with him?

18 A. I wanted to have the films available to help  
19 quantify what the radiologist reported.

20 Q. When you say to help quantify what the  
21 radiologist reported, are you indicating that the  
22 report wasn't clear to you, or that you just wanted  
23 to independently look at the films, or neither?  
24 I'm not sure what you mean by quantify.

25 A. The MRI scan report showed certain pathology,

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

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

5 A. Yes.

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

10 A. I wanted to review this.

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

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

19 A. Impression 2 and 3.

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

25 A. They used the word moderate, I wanted to

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

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

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

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

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

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

19      A.       I know him very well.

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

1 A. I don't recall.

2 Q. Do you think he was indicating that there was  
3 yet another examination that could be performed to  
4 better define the area?

5 A. He suggested a CT scan of the temporal bone  
6 in the text of the report, not in the impression.  
7 The impression stated that there was a recent CT  
8 scan and revealed sclerosis, suggesting chronic  
9 changes, so I assumed that was sufficient.

10 Q. Chronologically the CT that had been  
11 performed actually occurred before the MRI; do you  
12 agree with that?

13 A. Correct.

14 Q. The CT that was performed, you have that  
15 report?

16 A. Yes, I do.

17 Q. That did not image the mastoid region with  
18 specificity, did it?

19 A. It's not specified in it.

20 Q. Wasn't that CT one of the head?

21 A. Correct.

22 Q. Did you get the conclusion from looking at  
23 the films or from reading the report that the  
24 mastoid region had actually been imaged?

25 A. I really had no comment on the CT scan.



1 Q. Fair enough. The secondary finding you were  
2 concerned with was fluid in the mastoid region?

3 A. Correct.

4 Q. The indication by Dr. Pepe is that could  
5 represent an inflammatory process?

6 A. Correct.

7 Q. When a radiologist is reporting to you as the  
8 ENT that there is fluid in a particular region that  
9 could represent an inflammatory process, does that  
10 exclude the possibility that that fluid being  
11 imaged on this MRI is actually fluid caused by a  
12 neoplasm of some sort?

13 A. It's one of the possibilities.

14 Q. That's all I wanted to know.

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

20 I will probably go through your  
21 actual examination, but what I want to do is switch  
22 to the consult report that you ended up writing, if  
23 we could go there first.

24 A. Yes, I have it.

25 Q. Tell me in your own words, and you can use

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

6       A.       Yes.

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

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

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

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

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

1 A. Yes.

2 Q. In addition you felt he had sinusitis?

3 A. Mucosal thickening of the right maxillary  
4 sinus, sinusitis or allergies.

5 Q. Which of the two diagnoses that you have just  
6 named would be responsible for a headache behind  
7 the right eye, right temple, and back of the head?

8 A. None of these findings are the cause of that  
9 type of pain.

10 Q. What did you believe, if you had a belief of  
11 a diagnosis, was the cause of those pains that I  
12 just mentioned behind the right eye, the right  
13 temple, and back of the head?

14 A. Based on the introductory letter it was  
15 cluster headaches as diagnosed by Dr. Denton.

16 Q. Now, you gave him your own personal  
17 examination, and as an ENT what other conditions  
18 would cause those kind of symptoms that you would  
19 be treating?

20 MR. BEST: Which ones are  
21 we talking about?

22 MISS KOLIS: I am limiting  
23 myself to the right eye pain, the pain behind the  
24 right temple, and in the back of the head.

25 MR. BEST: I apologize. I

1 am not sure I understand what you are driving at

2 THE WITNESS: I don't either.

3 Q Initially I think you fairly answered the  
4 diagnosis that you would not account for the  
5 complaints of pain that r. Anderson had regarding  
6 paraesthesiae in the right eye, the right temple,  
7 and the back of the head on the right side?

8 A Correct.

9 Q You indicated that passed on to an introductory  
10 letter there had been a diagnosis of cluster  
11 headaches?

12 A. Correct.

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

18 A No.

19 Q Nothing else, okay

20 A Not those specific symptoms

21 Q Passed upon your experience in doing what you  
22 do for I guess that was almost 30 years, what  
23 symptoms at presentation suggest a neoplasm in the  
24 nasal cavity to you, are there some clinical  
25 symptoms that suggest these diagnoses?

1 A. In the sinus cavity?

2 Q. Correct.

3 A. The symptoms, usually a bloody show is the  
4 first sign, bleeding from the nose, unilateral  
5 bleeding, blood stained mucous, progressive  
6 obstruction, a nasal obstruction getting  
7 progressively worse, usually a foul odor, cacosmia,  
8 which is a foul odor.

9 Pain is usually a late onset due to  
10 bony erosion, and the sinus becomes totally  
11 opacified, x-rays show an obvious mass.

12 Q. So if I heard you correctly, I am trying to  
13 listen and I don't have time to write when I'm  
14 listening, the clinical symptoms that would lead  
15 you to have a concern for that kind of neoplasm  
16 would be a bloody show in the mucous?

17 A. Yes.

18 Q. Unilateral in nature?

19 A. Yes.

20 Q. An odor?

21 A. Usually a foul odor.

22 Q. What about facial pain or swelling?

23 A. Facial pain and swelling is usually a late  
24 finding when there is marked involvement of the  
25 sinuses, an erosion of the bone.

1        Whose would be the things that you would  
2        customarily expect to see to raise your level of  
3        suspicion?

4        A.    Showing up on the CAT scan, MRI scan,  
5        correct.

6        Q.    You indicated you had a brief opportunity to  
7        read the Akron City records from the summer of  
8        1997; am I stating that correctly?

9        A.    I reviewed it very quickly to see if they  
10        tried to reach me

11       Q     The kind of cancer that Mr. Anderson was  
12       diagnosed with, and I know I am not going to  
13       pronounce this correctly. Pterygopalatine -- am I  
14       saying that correctly?

15       A     Pterygopalatine fossa tumor

16       Q     In your 30 years of practice have you never  
17       been involved with a patient where that was the  
18       diagnosis?

19       A.    I never had a patient with that type of  
20       tumor

21       Q.    Would you know from having read literature,  
22       and I am speaking prior to the lawsuit, prior to  
23       actually never having seen Mr. Anderson, would you  
24       know how that particular type of cancer presents?

25       A.    No, ma'am.

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

6 MR. VOUDOURIS: Objection. Go  
7 ahead.

8 A. Please repeat that question.

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

11 -----  
12 (Question read.)

13 -----  
14 MR. VOUDOURIS: Objection. Go  
15 ahead.

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

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

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

1 TMJ or a bite problem.

2 Q. So your answer to my question is in fact you  
3 were attributing his ear pain to his bite problem?

4 A. Yes.

5 Q. Was there anything else; well, the serous  
6 otitis media, you felt that contributed to his ear  
7 pain?

8 A. Serous otitis media is rarely associated with  
9 ear pain.

10 Q. What about sinusitis?

11 A. Sinusitis rarely causes ear pain, unless it's  
12 an acute infection of the ear.

13 Q. You didn't determine this to be an acute  
14 infection?

15 A. In mastoiditis an acute infection you would  
16 be bulging, red, and dull; his is the opposite of  
17 dull, glassy.

18 Q. There was not an acute infective process at  
19 that time?

20 A. Right, since mastoiditis was ruled out.

21 Q. Can a neoplasm such as was eventually found  
22 in Mr. Andrews be the cause of ear pain?

23 A. I do not know if that is the presenting  
24 compliant. I honestly don't know.

25 Q. Do you think he had TMJ, did you think that's



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

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

10      Q.       You told him to see his dentist?

11      A.       Correct.

12      Q.       Did you know who his dentist was?

13      A.       No.

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

16      A.       Yes.

17      Q.       Can you tell me why that is?

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

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

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

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

1 of his bedroom?

2 A. He had a pet cat, and cats out of all  
3 furbearing animals cause most allergies.

4 Q. Do you know how long he had a cat?

5 A. No.

6 Q. He is obviously to discontinue smoking, that  
7 was to address what issues, general health of  
8 course, but anything that was contained to your  
9 diagnoses?

10 A. According to the history Mr. Andrews is a  
11 two pack a day smoker. People who smoke or even  
12 around smokers have up to six times more ear, nose,  
13 and throat problems than those who don't smoke.

14 Q. You were hoping discontinuation of smoking  
15 would show an improvement in his symptoms?

16 A. The sinus findings, as well as the fluid in  
17 his ears, correct.

18 Q. Referring to the beginning of this page it  
19 says this patient should discontinue his  
20 Beconase AQ and try Nasacort AQ at bedtime and  
21 Claritin in the morning?

22 A. Correct.

23 Q. First of all, were you aware at the time that  
24 you performed your physical and made these  
25 recommendations of all the medications he was on?

1       A.       I believe you have that.

2       Q.       That is the list?

3       A.       Yes, ma'am.

4       Q.       That is not your handwriting; is that your  
5       nurse's handwriting?

6       A.       I don't know, it doesn't look like my nurse's  
7       either.

8       Q.       The patient himself could have given that to  
9       you?

10      A.       I just have a photocopy, not the original,  
11      that's why I assume he brought that with him.

12      Q.       Why did you want him to try that particular  
13      combination of medications?

14      A.       My experience is that that combination worked  
15      better than the medicine he was on.

16      Q.       Which of those medications would have  
17      affected his serous otitis media?

18      A.       Both.

19      Q.       How would they have done that?

20      A.       By decreasing swelling, congestion from what  
21      I thought were allergic problems.

22      Q.       If taking those medications didn't cause a  
23      change in those symptoms, what would that have led  
24      you to conclude?

25      A.       That he wasn't compliant with my other

1 recommendations.

2 Q. If you found out he was compliant and hadn't  
3 changed the symptoms, what would that lead you to  
4 conclude?

5 A. That there was probably another process going  
6 on, you look at the next level, other causes.

7 Q. What alternative process would it suggest to  
8 you when you refer to looking at another level?

9 MR. BEST: So the  
10 hypothetical is clear, tell him what symptoms,  
11 which ones didn't -- what did the patient do.

12 Q. I thought I premised this series of questions  
13 on the serous otitis media.

14 My question to you was if the  
15 patient was compliant with the medication regimen  
16 you put him on, how long would he have needed to be  
17 on it and be compliant with it before you would  
18 expect to see an improvement with the serous otitis  
19 media?

20 A. Four weeks is a fair trial, if he is  
21 compliant with the other recommendation.

22 Q. Is that why you asked him to come back in a  
23 month?

24 A. Correct.

25 Q. To give it a four week trial?

1 A. At least a four week trial.

2 Q. If in fact hypothetically he was compliant  
3 with the Nasacort and Claritin, as you indicated --

4 MR. BEST: And everything  
5 else?

6 MISS KOLIS: And everything  
7 else.

8 Q. Let me ask it this way: If he was compliant  
9 with the Nasacort and Claritin, slept with Dacron  
10 pillows, kept all his pets and plants out of his  
11 bedroom, but wasn't able to quit smoking, would you  
12 expect for him to have improvement on that regimen?

13 A. Possibly not.

14 Q. Because of the smoking?

15 A. Correct.

16 Q. But if there was no improvement whatsoever,  
17 even hypothetically assuming if he was able to do  
18 everything, you indicated it would make you think  
19 of something else and go to the next level; what  
20 would it make you think and what next level would  
21 you be contemplating?

22 A. As I mentioned in this letter I would have  
23 thought about his very large tonsils, and I would  
24 have thought to evaluate him under anesthesia,  
25 possibly remove his tonsils and adenoids, and put a

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

3 Q. Those were the things you were thinking?

4 A. Yes.

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

8 Do you dictate your consultation  
9 notes?

10 A. Yes.

11 Q. Someone transcribes them for you?

12 A. Correct.

13 Q. Then you read them?

14 A. Yes.

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

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

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

23 A. Correct.

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

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

3 Q. I haven't had that privilege  
4 I'll be in order what those  
5 three handwritten -- I don't want to call them  
6 additions; when would you have put those on the  
7 paper?

8 A. I have it right here

9 MON ONE. question mark --

10 MS. BEST: the question is  
11 when would you have made the note?

12 THE WITNESS: I apologize

13 MR. WESSM: You're doing

14 fine

15 Q. When would you have made those notes?

16 A I dictated at the end of each day so the  
17 workup is fresh in my mind I dictated from the  
18 notes we have here filled out by both my assistant  
19 and myself We dictated that evening, usually it's  
20 transcribed within 24 hours I have read it.  
21 signed it, and got it mailed off

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

1       that's when these were done.

2       Q.       Can you tell me what those say?

3       A.       I put down here the mental notes to follow-up  
4       on, question mark, check sinus, see status if it  
5       was improving. Conservative therapy, plus or  
6       minus, septoplasty, possibility of doing possible  
7       septoplasty. Check the septum, question mark HIV.

8       Q.       Just so I am clear about what you were  
9       thinking at that time, that looks like a question  
10      mark to me?

11      A.       It is.

12      Q.       Question sinus?

13      A.       Question mark, check sinus.

14      Q.       When he came back you wanted to recheck his  
15      sinuses?

16      A.       I repeated the x-ray.

17      Q.       Is that your Waters view?

18      A.       Yes.

19      Q.       Of what benefit of doing a Waters view x-ray  
20      in evaluating the sinuses?

21      A.       This is our routine, my routine at the  
22      office, I see a patient with sinus problems, we get  
23      a baseline study, and we treat the problem  
24      conservatively. When they return we repeat the  
25      x-ray to see if it has improved, remained



1 unchanged, or got worse.

2 Q. Did you have some findings on your Waters  
3 x-ray?

4 A. Yes.

5 Q. What were those findings?

6 A. It appeared the patient had a possible mucous  
7 retention cyst of the maxillary sinus.

8 Q. What is a mucous retention cyst?

9 A. It consists of a blocked mucous gland, the  
10 lining of our sinuses, mucous membrane, and with  
11 infection and allergies it becomes blocked, fills  
12 up with trapped mucous, much like a balloon filled  
13 with water.

14 Q. What physical problems does it cause?

15 A. Rarely does it cause symptoms, it's an  
16 incidental finding. When you see it you think of  
17 allergies or infection.

18 Q. Anything else besides allergies and  
19 infections that can cause that retention cyst?

20 A. I can't think of anything else. Those are  
21 the most common causes.

22 Q. Then the next one is check --

23 A. Plus or minus, septoplasty.

24 Q. That is because he had a deviation in his  
25 septum?

1 A. Correct.

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

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

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

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

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

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

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

1 the enlarged tonsils are.

2 Q. That was a concern you had?

3 A. If the tonsils were larger, if the coating of  
4 the tongue was worse, then I would have evaluated  
5 him for HIV.

6 Q. That was going to be my next question.

7 You didn't send him for an HIV  
8 test?

9 A. I did not do that. I don't apply that label  
10 to patients off the bat.

11 Q. In your own mind you put question HIV, you  
12 were going to watch to see if his tonsils were more  
13 enlarged to you on the return visit?

14 A. I wanted to see if the antibiotic Biaxin was  
15 going to help him, and if the tonsils were larger  
16 and with the heavy coating of the tongue I would  
17 have evaluated him.

18 Q. I'm just asking if hypothetically he had  
19 returned to your office in one month and his  
20 tonsils were larger, would you at that point ask  
21 him to go for an HIV test?

22 A. Yes, ma'am.

23 Q. Did you at any time share those concerns with  
24 or express your thoughts with Dr. Stringham or  
25 Dr. Denton?

1       A.       No, I did not.

2       Q.       Can I conclude, and I might be in error, that  
3       these handwritten notes that you made, these  
4       three little or four, I thought there were three,  
5       but it's four indications in your handwriting,  
6       those didn't appear on the letter you sent to  
7       Dr. Stringham?

8       A.       No, ma'am.

9       Q.       Let's take a look at your physical  
10      examination, if you don't mind.

11                        You did a hearing test on  
12      Mr. Andrews. Can you tell me what the purpose was  
13      in performing that hearing examination?

14      A.       The decision to get an audiogram was based on  
15      my physical findings, and also the introductory  
16      letter from Dr. Stringham.

17      Q.       I'm sorry. Were you done with your answer?

18      A.       That's it.

19      Q.       What in the introductory letter caused you to  
20      believe that an audiogram would be a good idea?

21      A.       Dr. Stringham mentioned that there appeared  
22      to be a large posteroinferior perforation of the  
23      right eardrum.

24      Q.       You wanted to evaluate that?

25      A.       And confirm whether or not it was present.

1 Q. Was it present?

2 A. No.

3 Q. Do you have any idea why Dr. Stringham  
4 thought there was a perforation, and if you don't  
5 know, that's all right?

6 MR. VOUDOURIS: Objection.

7 A. I don't know.

8 Q. So you did that examination.

9 Your findings were, and I am going  
10 to generalize it, there was some hearing loss in  
11 both ears, correct?

12 A. Correct.

13 Q. Did you have any idea medically what the  
14 cause of the hearing loss was in the right ear?

15 A. Based on my findings due to a combination of  
16 nerve deafness from hypertension, cause  
17 undetermined, and the conductive component was due  
18 to the fluid in the ear.

19 Q. What about the left ear?

20 A. The left ear shows primarily a high frequency  
21 nerve loss, due to possible hypertension,  
22 circulatory changes, cause undetermined. There was  
23 some suggestion there might be otosclerosis based  
24 on the audiogram.

25 Q. Next, if you want to turn to your physical

1 examination sheet; it is this a standard office form  
2 that you have that you actually complete during the  
3 physical examination.

4 Q Both I and my doctor's assistant complete  
5 this

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

9 A Yes.

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

13 A Those initials

14 Q. Whose initials are those?

15 A Haney Belts, we have two physician  
16 assistants, and Haney was our that day

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

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

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

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

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

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

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

11       A.       3 plus tonsils are almost kissing each other.

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

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

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

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

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

4        A.        He is a gagger.

5        Q.        Were you using a mirror?

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

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

9        A.        Yes.

10       Q.        What?

11       A.        A flexible nasal throat scope.

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

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

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

20       A.        It reduced my level of suspicion.

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

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



1        abbreviation for mucous retention cyst.

2        Q.        It looked like MRI to me.

3        A.        MRC.    Right antrum, which is the right  
4        maxillary sinus.    Antrum is the medical term for  
5        maxillary sinus.

6        Q.        Underneath it you wrote?

7        A.        Reviewed MRI, parentheses, see reports.

8        Q.        Do you want to turn to the back page for me?

9        A.        Yes, ma'am.

10       Q.        At the top it listed Number 4 on your  
11       examination list, I don't follow why that is that  
12       way -- I see, never mind.

13                    You didn't do an examination of the  
14       neck?

15       A.        No.

16       Q.        You didn't feel it was indicated?

17       A.        No.

18       Q.        What structures are contained within the neck  
19       that could cause or contribute to ear or facial  
20       pain?

21       A.        I can't think of anything right now in the  
22       neck.

23       Q.        The next area is the face.    When you write  
24       face on your physical examination sheets, it's  
25       there if you do an examination of the face, I

1       guess?

2       A.       Correct.

3       Q.       I know it sounds silly, but when you have  
4       face on your sheet, as an ENT what would you be  
5       examining?

6       A.       Any paralysis, any asymmetry.

7       Q.       You didn't test Mr. Andrews' cranial nerve  
8       function, did you?

9       A.       No.

10      Q.       Isn't that part of a routine examination for  
11      an ENT?

12      A.       No, it's not.

13      Q.       What instance would you perform a cranial  
14      nerve examination?

15      A.       The only cranial nerve exam is the hearing  
16      aspect.

17      Q.       That is the only one you do?

18      A.       When patients present with their problems.

19      Q.       What about eyes, what does that mean?

20      A.       The eyes were examined, if indeed they have  
21      diplopia, any visual complaints, and there was none  
22      of that that I can recall.

23      Q.       Then the vestibular examination I think we  
24      just covered, you didn't get into that area; am I  
25      right?

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

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

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

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

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

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

25      A.       Those are my working diagnoses or

1 impressions.

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

5 A. DC Nasacort AQ, Q.h.s; Claritin,  
6 q. a.m. RTO, return to office, one month. No  
7 change, M/C, TNA, plus right myringotomy and tube.  
8 MT. Plus or minus septoplasty Question mark,  
9 rule out HIV, check sinus. see dentist

10 Dacron pillows, no pets, live  
11 plants in bedroom. DC smoking, and then question  
12 mark, hearing aid evaluation, HAE, hearing aid  
13 evaluation, and fitting, fitting of the hearing

14 aid

15 Q 10-10-96?

16 A See notes, refers to the phone call

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

23 A That was my suggestion yes

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

1 A. Correct.

2 Q. To amplify or clarify diagnoses?

3 A. To evaluate the patient for subacute  
4 mastoiditis.

5 Q. You did ask the patient to come back?

6 A. Yes.

7 Q. If I am reading the chart correctly, that  
8 visit was scheduled for sometime October 24th, I  
9 believe?

10 A. A month later.

11 Q. Prior to that scheduled office visit, your  
12 office received a phone call from Mr. Andrews; is  
13 that accurate?

14 A. Correct.

15 Q. Those are the yellow sticky notes in the  
16 back, is that the way your office keeps phone  
17 messages?

18 A. Yes.

19 Q. Can I gather the handwriting -- you can look  
20 in your own if you want to -- the handwriting, is  
21 that a nurse's handwriting, she is taking the  
22 information?

23 A. No, this is my secretary.

24 Q. So your secretary takes the phone calls,  
25 lists the complaints, and then communicates them to

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

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

9       Q.       You are probably seeing patients at that  
10      point?

11      A.       Correct.

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

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

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

24                               You were aware based on the  
25

1 period of at least three months?

2 A. Attributed to cluster headaches, yes, ma'am.

3 Q. You and I think that is Rx, probably,  
4 Claritin, Nasacort, et cetera.

5 It says over, do you see where it  
6 says over at the end; is that your handwriting?

7 A. My writing.

8 Q. We will come back to that, has gone through  
9 three bottles of Tylenol. Patient says he can't  
10 take anymore pain. Severe pain in right side from  
11 right eye up over temple, down behind ear and  
12 around to the jawbone, wants something for pain; am  
13 I have reading this sequentially?

14 A. Yes.

15 MR. VOUDOURIS: I think it says  
16 two bottles of Tylenol.

17 MISS KOLIS: Make sure it's  
18 two bottles.

19 Q. Wants something for pain, or to find out why  
20 he has pain, and then underneath it it says Rx; is  
21 that your prescription number?

22 A. That is the drugstore number, pharmacy  
23 number.

24 Q. He has already tried Imitrex, Seldane --

25 A. You left out allergic to Penicillin.

1           Q    What is happening there?

2           A    Yes. He told my secretary he was allergic to  
3 Penicillin.

4           Q.   He has already tried ampicillin, Septran,

5 Suprax, Calan PR, Maxasol, Sansert.

6 sulfa, trimethoprim, Glyatex; is that Ultram?

7           A    Yes, ma'am.

8           Q    Claritin, Biconase, Nasacort AQ; was that the  
9 end of that phone message?

10          A    Correct.

11          Q    Do you believe she gave it to you the same  
12 day?

13          A.   Yes, ma'am, to the best of my recollection.

14          Q    There are two phone calls that day, right?

15          A    Yes, to the best of my recollection there is  
16 a Number two.

17          Q    Let's deal with Number 1. At some point --  
18 you have no way of knowing what time of day you got  
19 these phone calls, what time you were able to look  
20 at the note; is that an accurate statement?

21          A    I don't know what day of the week this 10th  
22 of October, '98 was

23               MR. WEST:           She wants to  
24 know what time. If you don't know, that's okay.

25          Q.   It's okay.



1 A I don't know.

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

4 A. Based on what I have heard, yes, it must have  
5 been the same day.

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

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

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

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

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

24 A. Correct. I'm sorry about that.

25 That's all right.

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

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

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

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

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

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

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

24      A.       Yes.

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

1 not prescribed at that first encounter, correct?

2 A. Correct.

3 Q. Did you interpret the information which he  
4 gave to your secretary to indicate that he had an  
5 increase in pain, or that the pain was the same  
6 pain that you had seen him with on the 26th, but  
7 thinks what he was taking was ineffective to manage  
8 it?

9 A. I don't understand that question.

10 Q. You prescribed Darvocet, you had not done  
11 that at the first examination; we are in agreement  
12 with that?

13 A. Yes.

14 Q. You prescribed Darvocet for pain I gather,  
15 right?

16 A. Correct, for TMJ pain.

17 Q. Did you think this was a new onset or  
18 increase of pain from the time you had seen him on  
19 the 26th? I am just asking you if you know what  
20 you thought.

21 A. I didn't think it was a new pain. I wanted  
22 to address the TMJ problem.

23 Q. You didn't prescribe anything to address pain  
24 at the first physical examination of him?

25 A. He was sent to me for mastoiditis, I didn't

1 look into the pain aspect of it.

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

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

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

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

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

18 Q. I accept your explanation.

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

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

1 Q. Fair enough.

2 A. Every four to six hours for pain.

3 Q. Now, you indicate that the bottom line says  
4 tell patient will repeat CAT scan, ear and sinus.

5 When you wrote your consult letter  
6 to Dr. Denton you didn't indicate you were  
7 contemplating a CAT scan of the ear and sinus, did  
8 you?

9 A. I did not indicate that because at that time  
10 he had essentially negative results, the reports on  
11 his previous scans, he had two sets of scans.

12 Q. Why on October 10th did you want your  
13 secretary to tell Mr. Andrews that you would repeat  
14 the CAT scan of the ear and sinus?

15 A. If he wasn't getting better we always repeat  
16 it. If the patient is not getting better, if  
17 symptoms persist, if he doesn't respond to  
18 conservative therapy, we go back and re-evaluate at  
19 a different level.

20 Q. Apparently, and I am saying apparently  
21 because I can only conclude certain things, your  
22 secretary must have called Mr. Andrews and shared  
23 both your comments to him?

24 A. It's on the left upper hand corner, up here.

25 Q. Where it says call patient?

1 A. JR is Joyce Ridgeway.

2 Q. I was guessing she did because there are more  
3 notes, but that clarifies that.

4 Your secretary, is she instructed  
5 to relate to the patient each and every piece of  
6 information that you add around the note; do you  
7 know what question I am asking?

8 A. No, ma'am.

9 Q. Your secretary is not a physician, correct?

10 A. She is not.

11 Q. Is she a nurse?

12 A. No.

13 Q. How does she know what information to  
14 communicate to the patient based upon your note?

15 A. She has been instructed to convey what we  
16 have written.

17 Q. That was my question, I didn't ask it very  
18 well.

19 Would she say hi, Mr. Andrews --  
20 what did you say her name was?

21 A. Joyce.

22 Q. -- the doctor says it's okay for you to keep  
23 your appointment as scheduled, if you want to come  
24 in sooner, fine. He thinks what you are  
25 experiencing is due to your jaw pain. Do you see

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

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

8 Q. She gave him the information?

9 A. Correct.

10 Q. Then it has Jack Andrews number two?

11 A. Correct.

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

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

24 A. I don't know how she could have come to that  
25 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.



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

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

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

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

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

20 A. Correct.

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

1       A.       He was having symptoms that sounded like  
2       cluster headaches.

3       Q.       Those were right-sided facial pain from the  
4       eye up over the temple down from the ear to the  
5       jawbone?

6       A.       Right.

7       Q.       Dr. Milo, October 24th, 1996 came and went,  
8       Mr. Andrews did not come to your office?

9       A.       Correct.

10      Q.       What is your office's procedure regarding a  
11      no-show on a patient?

12      A.       If it's a post-op patient we call and ask why  
13      they didn't keep their post-op visit; nonsurgical  
14      patients we do not call or follow-up.

15      Q.       Since you have written to Dr. Stringham for  
16      Dr. Denton, I keep saying it that way, that is the  
17      way the letter came, would it be your policy to  
18      write a letter to the referring doctor indicating  
19      their patient had not shown up for their follow-up  
20      visit?

21      A.       No, it's not our policy unless it's a post-op  
22      patient, then we will question that.

23      Q.       In as much as the 10-10-96 telephone  
24      communication indicates that you were going to do a  
25      repeat CT of the ear and sinus, did you think you

1       should have written them a letter indicating you  
2       believe he probably needed one?

3       A.       No.

4       Q.       It's clear to you, and this is probably going  
5       to sound silly, when you indicated in that sentence  
6       there would be a repeat CT of the ear and sinus, in  
7       fact the ear and sinus had not been CT'd; is that  
8       an accurate statement?

9       A.       They were included in the scans.

10      Q.       He had comments on the sinus, and the mastoid  
11      in his MRI scan?

12      A.       Dr. Pepe made it in his report.

13      Q.       I just have a couple more.

14                       Dr. Milo, have you ever served as  
15      an expert of a doctor in a medical negligence case?

16      A.       Once.

17      Q.       When was that?

18      A.       Approximately three years ago.

19      Q.       Was that in Summit County?

20      A.       Yes, ma'am.

21      Q.       Who was the doctor that you were opining for  
22      I guess is the word; do you remember?

23      A.       I believe it was a Dr. Ciraldo, general  
24      surgeon.

25      Q.       Fair enough.

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

3 A. No, I do not.

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

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

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

14 A. No one called.

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

17 A. Yes, correct.

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

21 THE WITNESS: Thank you.

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

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

4                                       - - - - -

5                                       CROSS-EXAMINATION

6     BY MR. VOUDOURIS:

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

11    A.       That is correct.

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

16    A.       Yes.

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

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

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

1 30 days?

2 THE WITNESS: Yes, ma'am.

3

4 -----

5

6 (Deposition concluded; signature not waived.)

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# ERRATA SHEET

## NOTATION

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1. The first step is to identify the problem. This involves understanding the current situation and what needs to be achieved.

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1. The first part of the document is a title page. It contains the title of the document, the author's name, and the date of the document.

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1. The first part of the document is a header section containing the title "THE EFFECTS OF THE 2008 FINANCIAL CRISIS ON THE UK ECONOMY" and the author's name "JAMES H. M. SMITH".

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WISCONSIN DEPARTMENT OF REVENUE

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**◆ 重要提示 ◆**

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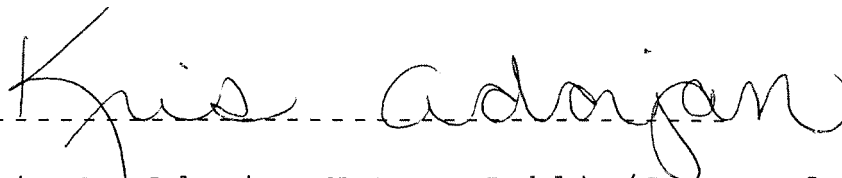
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3 I, Kris A. Adorjan, Notary Public within and  
4 for the State of Ohio, do hereby certify that the  
5 within named witness, ANTON P. MILO, M.D., was by  
6 me first duly sworn to testify the truth in the  
7 cause aforesaid; that the testimony then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

18 IN WITNESS WHEREOF, I have hereunto set my hand and  
19 affixed my seal of office at Cleveland, Ohio, this  
20 1ST day of APRIL, 1999.

21   
22 -----

23 Kris A. Adorjan Notary Public/State of Ohio.

24 Commission expiration: 11-30-02.  
25



**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: 50NUMBER 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

<b><u>PAGE / LINE</u></b>	<b><u>DESCRIPTION</u></b>
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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
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6 / 6	Brought his office chart with him
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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
9 18	Not boarded in surgery, just otolaryngology and head & neck surgery
9 / 12	Performs benign and malignant tumor surgery of the head & neck
9 1 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
10 12	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
- 1217 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)
- 1615 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

24/ 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

25/ 18 Because feathered pillows, as Jack had, causes allergies and sinusitis

25/ 122 Would have recoinnended being tested for allergies if Jack didn't get better; otherwise conservative treatment is followed

26/ 12 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

27/ 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/ 20 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/ 13 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
- 32 121 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
- 33 16 Appearance of possible mucous retention cyst of the maxillary sinus
- 33 19-13 A blocked mucous gland
- 33 115 Rarely causes any problems; incidental finding
- 34 / 1 +/-, septoplasty was because Jack had a deviated septum
- 34 / 5-8 Was thinking of doing a septoplasty when doing the TandA and tube insertion
- 34 / 9-12 At Jack's follow up, wanted to see how involved the septum was
- 34 / 15-21 Enlarged tonsils and a heavy coating of the tongue is one of the first signs of HIV
- 35 / 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
- 36 1 1 Did not share those concerns with Denton or Stringham

#### REVIEW OF PHYSICAL EXAM

- 36 1 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
- 37 13 Same was not present
- 37 1 12 Diagnosed some hearing loss in both ears
- 37 / 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 from 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 10/24, one month later

46 / 3-8 When patients call, the secretary writes message on a yellow sticky, 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

46 / 19 Reading of phone message into record

48 / 15 Jack had made 2 phone calls that day asking for something to relieve the pain

49 / 14 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 from 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 / 15-19 On 10/10 wanted Jack to know that; if/because patient doesn't get better, they always repeat

54 / 18 Secretary is not instructed to relay each and every piece of information

54 / 15 She conveys 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
- 58 11 Feels patient was calling with pain symptoms sounding like cluster headaches
- 58 19 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
- 58/2 1 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
- 60 16 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