

IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

PATRICIA A. YURICK, Executrix

of the Estate of

MARTIN A. YURICK,

Plaintiff,

vs.

Case No.

CLEVELAND CLINIC FOUNDATION,

326719

et al.,

Defendants.

- - - - -

Deposition of DAVID J. MOLITERNO,
M.D., called for examination under the statute,
taken before me, Denise M. Munguia, a Registered
Merit Reporter and Notary Public in and for the
State of Ohio, pursuant to notice and
stipulations of counsel, at the Cleveland Clinic
Foundation, 9500 Euclid Avenue, Cleveland, Ohio,
on Wednesday, May 5, 1999, at 2:20 o'clock p.m.

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1 DAVID J. MOLITERNO, M.D., of lawful age,
2 called for examination, as provided by the Ohio
3 Rules of Civil Procedure, being by me first
4 duly sworn, as hereinafter certified, deposed
5 and said as follows:

6 EXAMINATION OF DAVID J. MOLITERNO, M.D.
7 BY MR. FINELLI:

8 Q. Doctor, for the record, can you
9 state your full name and spell your last name?

10 A. David John Moliterno, M, as in
11 Mary, O L I T E R N O.

14:21:10

12 Q. You're a young guy, aren't you?
13 Relatively, I guess.

14 My name is Dan Finelli, I represent
15 the plaintiffs in this case which have named
16 Cleveland Clinic Foundation as defendants. I'm
17 going to be asking you a series of questions
18 this afternoon. If you don't understand any
19 question, please stop me, I'll rephrase it or
20 repeat it so that you understand it before you
21 answer it. Fair enough?

14:21:20

14:21:32

22 A. Fair.

23 Q. Most importantly, you need to keep
24 your voice up for the court reporter and your
25 responses need to be verbal responses --

14:21:41

1 A. Okay. 14:21:43

2 Q. -- so the court reporter can take
3 down your responses. Okay?

4 A. Okay.

5 Q. I am going to do things a little 14:21:50
6 bit different than my usual depositions. I'd
7 like to talk first about the drug ReoPro and
8 then talk about the clinical trials and the
9 study trials that were involved with those
10 types of medications. 14:22:01

11 A. Sure.

12 Q. Can you tell me what ReoPro is?

13 A. It's an antiplatelet drug.

14 Q. What's its specific action?

15 A. It binds, ReoPro binds to the 14:22:14
16 IIb/IIIa. Is that good enough? It's Roman
17 numeral II, small B, slash, Roman numeral III,
18 small A.

19 It binds the receptors on platelets
20 inhibiting them from binding their usual 14:22:28
21 ligand, the usual thing that it binds,
22 fibrinogen, so that the platelets can't couple
23 easily with other platelets.

24 Q. Okay. Fair enough to say, then,
25 the ReoPro inhibits the mediator which 14:22:43

1 causes -- which does not cause platelet 14:22:51
2 aggregation?

3 A. You'll have to redo that one for
4 me. Sorry.

5 Q. Okay. ReoPro blocks glycoprotein 14:22:57
6 IIb/IIIa, correct?

7 A. Yes. Correct.

8 Q. Thereby blocking the final common
9 pathway which facilitates platelet aggregation?

10 A. Correct. 14:23:10

11 Q. So that giving ReoPro diminishes
12 the ability of the platelets to aggregate?

13 A. That's correct.

14 Q. Are you familiar with the EPIC
15 trial? 14:23:21

16 A. Yes.

17 Q. Was the Cleveland Clinic involved
18 in the EPIC trial?

19 A. Yes.

20 Q. As a center? 14:23:27

21 A. Yes.

22 Q. When was the EPIC trial initiated?

23 A. Don't know.

24 Q. Do you know when it was completed?

25 A. I don't know the exact day, no. 14:23:37

1 Q. Okay. 14:23:39

2 A. I mean I can give you a ballpark
3 for most of the studies, but I just don't
4 remember the details. Sorry.

5 Q. Were you yourself involved with the 14:23:46
6 EPIC trial?

7 A. Not at the time of its workings,
8 no. I mean I helped with patient enrollment,
9 but I wouldn't have been in the design or
10 creation of the study. But I have certainly 14:23:56
11 worked on it and the publications from it
12 since.

13 Q. Let me tell you what I think the
14 EPIC trial is and correct me if I'm wrong.

15 A. Sure. 14:24:08

16 Q. It was a randomized, double
17 randomized study evaluating the efficacy of
18 ReoPro in patients undergoing angioplasty, the
19 purpose, to see whether or not that could
20 diminish the restenosis rate postangioplasty? 14:24:21
21 Correct?

22 A. No, I think the primary endpoint of
23 the study, as I understand, was trying to
24 prevent ischemic complications, that's the IC
25 of EPIC, the evaluation of the stroke to 14:24:37

1 prevent ischemic complications. Not 14:24:39
2 necessarily the prevention of restenosis, which
3 would be another sequelae perhaps of
4 percutaneous interventions.

5 Q. So that the primary composite was? 14:24:51

6 A. Death, myocardial infarction and
7 urgent target vessel revascularization, and
8 there were a few other minor points such as
9 placements of stent, placement of an
10 intra-aortic balloon pump, things such as that. 14:25:07

11 Q. And in the randomized study they
12 used a bolus of ReoPro along with an infusion
13 of ReoPro or a bolus of ReoPro along with a
14 placebo infusion or a placebo bolus along with
15 a placebo infusion? 14:25:23

16 A. That's correct.

17 Q. What they found was that the
18 treatment utilizing the ReoPro bolus and the
19 ReoPro infusion was associated with a higher
20 incidence of bleeding complications, the risk 14:25:37
21 being inversely related to byway?

22 A. That's an oversimplification, but
23 that's part of it, yes.

24 Q. Is it fair to say that using the
25 ReoPro bolus and infusion compared to the 14:25:53

1 placebo there was an increased risk of bleeding 14:25:55
2 complications?

3 A. There was an increased risk of
4 major bleeding associated with vascular sites
5 or hollow organ bleeding among those getting 14:26:06
6 ReoPro bolus plus infusion as compared with
7 those getting placebo.

8 Q. Are you familiar with the article
9 by Dr. Eric Topol from the Cleveland Clinic in
10 1995 titled The Prevention of Cardiovascular 14:26:22
11 Ischemic Complications with New Platelet
12 Glycoprotein IIb/IIIa inhibitors?

13 A. I may be, but I'm not sure which
14 one. He wrote several that year with similar
15 titles, so if you told me maybe where and when 14:26:36
16 it was published, I could have a better
17 connection for you.

18 Q. How about if I show you the
19 article?

20 A. Perfect. 14:26:43

21 Q. All right.

22 A. I'm not very familiar with that
23 one, but I can still answer your questions
24 about it.

25 Q. Okay. 14:27:07

1 A. You want me to leave it here or we
2 can trade it back and forth just so I can
3 figure out which one that is?

14:27:09

4 MR. JONES: I'll figure it out for
5 myself, too. Go ahead.

14:27:16

6 Q. Basically that article discussed
7 the results of recent clinical trials, mostly
8 the EPIC trial --

9 A. Yes.

10 Q. -- evaluating the efficacy and
11 safety of glycoprotein IIb/IIIa inhibitors in
12 patients undergoing PTCA, correct?

14:27:23

13 A. Yes.

14 Q. Okay. Based on that article and
15 the conclusions of the EPIC trial, was it not
16 the principal disadvantage of treatment with
17 the ReoPro bolus and infusion was it doubling
18 in the incidence of major bleeding?

14:27:42

19 A. It is among the limitations, yes.

20 Q. Therefore it was necessary as a
21 conclusion of the EPIC trial to minimize
22 bleeding complications by either reducing the
23 heparin dose or adjusting the dose of the
24 glycoprotein IIb/IIIa inhibitor?

14:28:01

25 A. Not necessarily. Now, let me help

14:28:16

1 clarify.

14:28:18

2 Q. Okay.

3 A. And I'll speak to you.

4 Because bleeding was reportedly
5 higher, efforts were made to try to minimize

14:28:29

6 bleeding while maintaining efficacy, but

7 because the bleeding was not planned in

8 advance, but somewhat of a surprise, the

9 adjudication of bleeding events wasn't quite as

10 strict as it could have been, for example

14:28:51

11 guidelines for blood transfusions weren't

12 organized in advance, so that subsequent trials

13 paid particular attention to categorization of

14 bleeding, guidelines for transfusions. Among

15 things that were decided to test in future

14:29:05

16 studies were lowering the heparin dose,

17 removing the vascular sheath quickly, because

18 that is the leading cause of major bleeding,

19 and perhaps adjusting the dose of the infusion

20 among lighter weight patients from a standard

14:29:21

21 ten microgram per kilogram to the per kilogram

22 basis as opposed to one dose for each patient.

23 Q. Weight adjusted dose?

24 A. Thank you, weight adjusted

25 infusion.

14:29:35

1 Q. And that all came about as a 14:29:38
2 conclusion of the EPIC trial?

3 A. I don't know if that's true or not.

4 Q. In the EPIC trial, heparin dosing
5 was not weight adjusted? 14:29:44

6 A. To my understanding of the
7 protocol, I think that's true.

8 Q. Okay. And what they found was
9 light patients, at least less than 99
10 kilograms, had more blood loss? More bleeding? 14:29:56

11 A. Relative to which group, I guess?

12 Q. I think relative --

13 A. For example, if you add ReoPro into
14 the formula, it did not seem to increase the
15 bleeding among lightweight patients. There was 14:30:11
16 a similar amount of bleeding for all. It
17 wasn't an independent predictor.

18 Q. Correct, but as compared to all
19 three regimens that were used, lighter people
20 had more problems with bleeding? 14:30:24

21 A. In general, so for heparin alone, I
22 think what was found in the studies, that all
23 three groups showed a similar amount of bleed.
24 It was higher than we would like to see for
25 lightweight patients, but wasn't disparate 14:30:36

1 among the groups. Does that make sense? 14:30:39

2 Q. Yes.

3 A. Okay.

4 Q. So that lower body weight was

5 associated with higher levels of 14:30:47

6 anticoagulation as measured by ACT?

7 A. For the same given dose of heparin,

8 yes.

9 Q. And higher doses of heparin on a

10 per kilogram basis was associated with higher 14:31:01

11 rates of major bleeding, with no efficacy

12 benefit?

13 A. In this study?

14 Q. Uh-huh.

15 A. Yeah, I don't think that was a 14:31:13

16 hypothesis of this, I mean I don't think that

17 was --

18 Q. I mean a conclusion you could call

19 it?

20 A. I'd have to see it to be sure. 14:31:21

21 Q. I guess what I'm trying to

22 summarize is that in this study it was observed

23 that higher than necessary doses of heparin

24 were associated with bleeding in those patients

25 where ReoPro was used as well? 14:31:57

1 A. I can't agree with that.

14:32:02

2 Q. Why not?

3 A. Because you said higher than
4 necessary and that's speculative. We don't
5 know what necessary is, for example. There are
6 no prospective studies comparing various
7 heparin doses for efficacy and safety outcome.

14:32:07

8 The derivation of the dose of
9 heparin used is an empiric one based on
10 observational data during cardiopulmonary
11 bypass by anesthesiologists. So the correct
12 dose of heparin has never been fully tested.

14:32:24

13 Q. I'm looking at your CV here that
14 you gave me and it's up to date, correct?

15 A. Yes.

14:32:42

16 MR. FINELLI: I'd just like to mark
17 this as Plaintiff's Exhibit 1.

18 - - - - -

19 (Thereupon, Plaintiff's Deposition
20 Exhibit 1 was marked for purposes of
21 identification.)

22 - - - - -

23 Q. In 1995 you were a staff physician
24 here at the Cleveland Clinic, correct?

25 A. At that time I was a staff

14:32:59

1 physician. I joined in July of 1994.

14:33:01

2 Q. Right. So in 1995 you would have
3 been a staff physician?

4 A. (Nodding affirmatively.)

5 Q. In the section of interventional
6 cardiology?

14:33:08

7 A. (Nodding affirmatively.)

8 Q. Okay. At that point in time, in
9 1995, then, what did you learn from the EPIC
10 trial?

14:33:20

11 A. That this class of drug
12 dramatically lowered the risk of death,
13 myocardial infarction or urgent target vessel
14 revascularization beyond contemporary therapy.
15 In EPIC we saw 35 percent reduction in those
16 adverse events.

14:33:34

17 Subsequent analyses of those data
18 had shown that mortality alone is reduced by
19 about sixty percent at three years among
20 patients who present with unstable angina.

14:33:47

21 Q. What did you learn with relation to
22 the bleeding or hemorrhage?

23 A. Yes. Again, since that wasn't, I
24 think, carefully designed, let us say, because
25 it wasn't suspected to be, we didn't need to

14:34:02

1 know perhaps, that we needed to, in designing 14:34:06
2 future studies, more carefully collect the
3 data.

4 Q. When you say it wasn't designed
5 carefully, there was a protocol dose of ReoPro 14:34:15
6 that was given as a bolus, correct?

7 A. (Nodding affirmatively.)

8 Q. There was a protocol dose of ReoPro
9 that was given as an infusion?

10 A. That's correct. 14:34:26

11 Q. There was a protocol dose of
12 heparin that was given as an infusion?

13 A. I don't know about the protocol
14 dose of heparin, but certainly for the
15 treatment groups the ReoPro was certainly 14:34:37
16 designed in advance, but what I was trying to
17 get at with regard to categorization of
18 bleeding, for example, this wasn't adjudicated
19 and, to my knowledge, and, for example,
20 guidelines for blood transfusions weren't given 14:34:49
21 such that there was a large variation among
22 hospitals for when they decided to transfuse
23 patients.

24 So that subsequent studies then, I
25 think more carefully tried to control these 14:35:05

1 assessments to get a more accurate handle on 14:35:08
2 adverse events. Whereas I think the primary
3 endpoint of EPIC was looking for efficacy.

4 Q. All right.

5 A. Again, a reduction in death, MI or 14:35:19
6 urgent target vessel revascularization.

7 Q. But as a side, what came out in
8 EPIC was shown that ReoPro bolus and infusion
9 doubled the increase of bleeding?

10 A. Was associated with an increase in 14:35:33
11 bleeding.

12 Q. Associated with increased bleeding
13 compared to placebo?

14 A. But it was unclear whether there
15 was because of the vascular sheaths were being 14:35:42
16 left in overnight, because of the heparin
17 needed to be weight adjusted, because of a
18 number of variables, but just in contemporary
19 practice at that time there was an association
20 with increased bleeding, yes. 14:35:55

21 Q. And would you agree as a result of
22 the EPIC trial, then, further trials focused,
23 at least partially focused, on decreasing the
24 dose of heparin to a low dose, weight adjusted
25 dose? 14:36:13

1 A. Yes, I think several efforts were 14:36:17
2 made to reduce vascular access site bleeding,
3 which again is a major bleeding in these
4 studies, by reducing the time an indwelling
5 sheath was left in the femoral artery, by 14:36:31
6 weight adjusting the dose of heparin, by weight
7 adjusting the infusion of ReoPro, by guiding
8 the level of hematocrit at which transfusions
9 would be given, by making meticulous access to
10 the femoral artery so that you wouldn't have an 14:36:52
11 increased risk of bleeding.

12 So I think a number of efforts, in
13 answer to your question, were made to try to
14 minimize the bleeding.

15 Q. But the vascular access site wasn't 14:37:02
16 the only site of bleeding that was involved
17 with EPIC?

18 A. The overwhelming majority are
19 hollow organs, almost all bleeding associated
20 with EPIC is hollow organs, specifically the 14:37:14
21 vasculature, number one, and then coming in
22 number two and three would be the
23 gastrointestinal tract and the genitourinary
24 tract, all the hollow organs, whereas solid
25 organs are almost never seen to bleed, we would 14:37:28

1 call them rare, and none have been shown to be 14:37:32
2 increased with ReoPro, specifically the spleen,
3 the liver, the brain, things that are solid
4 organs.

5 Q. Were there any patients that had 14:37:42
6 intracerebral hemorrhage in EPIC?

7 A. Yes. There were two, to my
8 knowledge, in the placebo group, there was one
9 in the bolus alone group, and there were
10 another two in the ReoPro bolus plus infusion, 14:37:56
11 there was a third one reported in that group,
12 but the patient never received ReoPro.

13 So it was deemed from that study
14 that there was no difference between -- sorry,
15 among the three groups. 14:38:11

16 Q. But whether it was access site,
17 hollow organs, as you say, or spleen, liver,
18 brain, the studies that followed EPIC were
19 using variables in the dosage of heparin and
20 ReoPro to help reduce the incidence of 14:38:40
21 bleeding, no matter where it occurred?

22 A. I don't know that. I think the
23 goal was to reduce major bleeding, which was
24 primarily associated with vascular access site,
25 so that's why among the major changes, again, 14:38:53

1 were removing the sheath to not giving post 14:38:57
2 procedural heparin, unless necessary, to giving
3 weight adjusted heparin, as we have talked
4 about, and weight adjusted ReoPro infusion.

5 Q. All right. Are you familiar with 14:39:09
6 the PROLOG study?

7 A. Yes.

8 Q. What was the PROLOG study?

9 A. The PROLOG was the first attempt in
10 a small scale fashion to do those things we 14:39:19
11 just mentioned.

12 Q. And that used ReoPro with standard,
13 standardized heparin dosage versus ReoPro with
14 low dose heparin?

15 A. With reduced dose heparin, yes. 14:39:33

16 Q. And what were the results of
17 PROLOG?

18 A. Yeah, I don't know them exactly, it
19 was a small study, but I think in short what
20 was found is that by removing the vascular 14:39:43
21 access site, by reducing the heparin dose, that
22 there was less bleeding as seen in EPIC. With
23 those modifications.

24 Q. Without the reduction of efficacy?

25 A. I think that's a fair conclusion, 14:40:01

1 but because it was such a small study, I'm not
2 sure that the statistical power would be robust
3 enough for that. I don't know, to be honest.

14:40:02

4 Q. Okay. PROLOG was a pilot study for
5 EPILOG?

14:40:13

6 A. Yes.

7 Q. EPILOG used the same randomized
8 protocol?

9 A. I believe so. I know the EPILOG
10 protocol, but PROLOG, since it was such a small
11 study, I never focused on it too much.

14:40:21

12 Q. All right. If I said they used the
13 same randomized protocol, there's no reason to
14 disagree?

15 A. I wouldn't disbelieve you, thank
16 you.

14:40:31

17 Q. And I think in EPILOG they also
18 randomized it between ReoPro and standard dose
19 heparin versus ReoPro and weight adjusted
20 heparin?

14:40:41

21 A. I think they were all weight
22 adjusted, to my knowledge. I think that the
23 regimens were as follows: Placebo, standard
24 dose heparin a hundred units per kilogram;
25 ReoPro, standard dose heparin, a hundred units

14:40:53

1 per kilogram; and ReoPro and reduced heparin,
2 70 units per kilogram.

14:40:56

3 Q. Approximately two-thirds of the
4 standard dose?

5 A. Seventy percent.

14:41:03

6 Q. Seventy percent. Okay. Except
7 EPILOG used a much greater patient population
8 in their trial?

9 A. I'm sorry, much greater?

10 Q. Much greater population than
11 PROLOG?

14:41:11

12 A. Sorry, thank you, yes. I thought
13 you were talking in comparison with EPIC.

14 Q. No.

15 A. A larger study, yes.

14:41:18

16 Q. Results were the same? What were
17 the results in EPILOG?

18 A. Well, EPILOG, as you probably know,
19 was prematurely discontinued, so the study was
20 never truly completed, not quite as robust.

14:41:27

21 Sample size had been greater because it was
22 deemed perhaps unethical to give patients
23 placebo and they should get ReoPro as a data
24 safety monitoring, board said. In brief,
25 efficacy was preserved in the lower dose

14:41:41

1 heparin group as compared with the higher dose
2 heparin group.

14:41:44

3 Q. And also did it not reduce
4 significantly the incidence of bleeding?

5 A. As compared with?

14:41:54

6 Q. With the standard dose.

7 A. I think in comparison with EPIC,
8 but the standard dose heparin group, I don't
9 remember the exact numbers, but the bleeding
10 was lowered, yes.

14:42:04

11 Q. Using the low dose weight adjusted
12 heparin in EPILOG?

13 A. I'm sorry, I would have to look at
14 the manuscript to actually see the actual
15 numbers again, but I don't remember if they
16 were, I don't think there was a difference
17 between the bleeding in the low dose and the
18 standard heparin dose between the two, but I
19 would have to look at it. They looked at minor
20 bleeding, major bleeding, they looked at a
21 number of things, and I'm sure we can have the
22 manuscript, I just don't have it on the top of
23 my head.

14:42:14

14:42:25

24 Q. All right. I think the incidence
25 of bleeding was significantly reduced with

14:42:32

1 ReoPro and low dose adjusted heparin compared 14:42:34
2 to ReoPro and standard dose heparin.

3 A. Okay.

4 Q. Okay. But you're unsure of that
5 conclusion, is what you're saying -- 14:42:43

6 A. Well, as I say --

7 Q. -- without looking at the --

8 A. -- there are a number of different
9 parameters, looked at major bleeding, minor
10 bleeding, blood transfusion, platelet 14:42:50
11 transfusion, and it's just hard for me to
12 remember the exact numbers.

13 Q. All right. What was CAPTURE? What
14 was that trial or study?

15 A. CAPTURE was a European-based study 14:43:01
16 that, once identifying patients who were deemed
17 to be at high risk for procedural complications
18 of angioplasty after a diagnostic
19 catheterization, were then randomized a placebo
20 or to ReoPro in an interval of 18 to 24 hours 14:43:17
21 before going on to their intervention, they had
22 their intervention, then received one hour of
23 ReoPro after the procedure and then it was
24 discontinued.

25 Q. Did any conclusion -- has CAPTURE 14:43:32

1 been concluded?

14:43:33

2 A. The study is concluded, yes.

3 Q. Have the results of CAPTURE altered
4 or changed the way you use ReoPro, the protocol
5 of ReoPro and heparin in your angioplasties?

14:43:46

6 MR. JONES: Objection. You're not
7 giving us a time frame?

8 MR. FINELLI: No. Since the
9 conclusion of CAPTURE.

10 MR. JONES: Objection. Go ahead.

14:43:56

11 A. Well, I think that -- no.

12 Q. I would think not, but --

13 A. I think EPIC and EPILOG have
14 primarily driven the way in which practice in
15 North America goes and I don't think the
16 CAPTURE protocol has been adopted in the United
17 States.

14:44:11

18 Q. All right. Other than EPIC,
19 PROLOG, EPILOG and CAPTURE, have there been any
20 other trials or clinical studies that have been
21 completed or ongoing regarding glycoprotein
22 IIb/IIIa inhibitors?

14:44:25

23 A. Yes.

24 Q. What are they?

25 A. There are too many to mention.

14:44:35

1 There are like 30 pharmaceutical companies 14:44:36
2 developing IIb/IIIa receptor antagonists in
3 phase I, II, III and IV studies, so I would say
4 the contemporary literature probably has data
5 maybe on 50,000 randomized cases. 14:44:48

6 Q. Are any of those as large as EPIC
7 or EPILOG?

8 A. Yes.

9 Q. Which ones? If you know.

10 A. Well, the oral IIb/IIIa trials, so 14:44:58
11 ORBIT, somewhere around nine, ten thousand
12 patients, EXCITE, similarly nine, ten thousand
13 patients.

14 Q. ORBIT, EXCITE, I'm sorry?

15 A. Yes. EXCITE, PARAGON, 14:45:12
16 P A R A G O N, PRISM, PRISM PLUS, I could go on
17 for quite a while. I think I reported on
18 medical studies of these in about 30,000 of
19 randomized patients about a year ago.

20 Q. These trials or studies that you 14:45:29
21 have just mentioned, have they all been
22 subsequent to EPILOG?

23 A. Yes.

24 Q. In 1994 were there any other
25 glycoprotein IIb/IIIa inhibitors studied other 14:45:33

1 than ReoPro? 14:45:37

2 A. Yes, but I don't know in what
3 phase, maybe in phase I or preclinical studies,
4 but none were, to my knowledge, in 94.

5 Q. Or 95. 14:45:51

6 A. Yeah, 95 probably would have been
7 the early studies with the current FDA approved
8 drug Aggrastat, A G G R A S T A T, and
9 Integrilin, so the impact and restore studies
10 would have been started about that time, I 14:46:05
11 would guess.

12 Q. But regarding the EPIC trial,
13 ReoPro was the only glycoprotein IIb/IIIa --

14 A. That's the only antiplatelet drug
15 used. 14:46:14

16 Q. -- that was utilized in the study?

17 A. That's correct.

18 Q. Did you hear my complete -- I
19 wanted to finish my question first.

20 A. Sorry. 14:46:21

21 Q. I don't know if you heard, my
22 question, let me repeat it, was in the EPIC
23 trial, ReoPro was the only glycoprotein
24 IIb/IIIa inhibitor utilized in the study?

25 A. Yes. 14:46:32

1 Q. In patients undergoing PTCA 14:47:06
2 procedure, angioplasty, where ReoPro is used
3 along with any concomitant heparin, if
4 substantial bleeding occurs that cannot be
5 controlled by pressure, you would agree, then, 14:47:25
6 that the ReoPro and the heparin should be
7 stopped?

8 A. Yeah, could you repeat the
9 question?

10 Q. Okay. Sure. 14:47:40

11 A. Just because I think it was
12 somewhat broad. So first I'll just say that
13 heparin is always used with ReoPro, almost
14 always used.

15 Q. All right. Let me repeat it. In 14:47:47
16 patients undergoing angioplasty, PTCA, where
17 ReoPro and heparin is used, either as a bolus
18 or an infusion, okay, and significant bleeding
19 occurs, which cannot be controlled by pressure,
20 such as at a vascular site, you would agree 14:48:05
21 then that the infusion of ReoPro and heparin
22 should be stopped?

23 A. I would say generally yes. I mean
24 it's a risk and benefit, it depends on why it's
25 being given and what the significant, in 14:48:17

1 quotation marks, risk of bleeding is, but I 14:48:21
2 think, yeah, in general you want to stop the
3 anticoagulants for a bleeding person.

4 Q. Going back to your CV, after
5 completing medical school and your internship, 14:48:53
6 you did a residency in internal medicine,
7 correct?

8 A. Yes.

9 Q. And then you did a fellowship at
10 Parkland Memorial Hospital in cardiovascular 14:49:00
11 medicine from 1990 to 93?

12 A. Yes.

13 Q. And then subsequent to that you did
14 a fellowship in interventional cardiology at
15 the Cleveland Clinic from 93 to 94? 14:49:11

16 A. Yes.

17 Q. That was two years, right? Or one
18 year?

19 A. It was one year.

20 Q. One year. All right. 14:49:18

21 Are you familiar with the American
22 Heart Journal?

23 A. Yes.

24 Q. Is it a monthly journal?

25 A. I believe so, yes. 14:49:30

1 Q. Do you review it? 14:49:31

2 A. Do I review the manuscripts for it?

3 Q. Well, do you review the American
4 Heart Journal when it comes out monthly?

5 A. Sometimes. I don't subscribe to 14:49:44
6 it, how is that, but, yes, I do review
7 manuscripts for it, but I don't read every
8 issue, no.

9 Q. Do you review any other monthly
10 journals? 14:49:49

11 A. I subscribe to and try to read,
12 when I have time, the New England Journal of
13 Medicine, the Circulation, the American Journal
14 of Cardiology, Lancet. Annals in Internal
15 Medicine, I forgot to say that. 14:50:05

16 Q. Would the American Heart Journal be
17 included in those that you mentioned?

18 A. (Nodding negatively.)

19 Q. Why not?

20 A. Just I guess it's a limit to the 14:50:15
21 amount of one's time to, you know, subscribe
22 and read the journals, and I would kind of give
23 it a lower rating in the respectability.

24 Q. Relative to what, the articles that
25 are published? 14:50:29

1 A. The ones that I mentioned that I do 14:50:29
2 read, the New England Journal of Medicine, for
3 example, and the Circulation are what we would
4 call the top tier or the tier II and the
5 American Heart Journal would maybe fall down to 14:50:39
6 a third level journal because it's just not
7 quite as well respected, I think.

8 Q. Well, respected in terms of the
9 articles that are published in the journal?

10 A. I think relative to other journals 14:50:49
11 like the New England Journal of Medicine, for
12 example, right.

13 Q. I think I asked you this before,
14 Cleveland Clinic was involved with EPIC?

15 A. Correct. 14:51:05

16 Q. Was it involved with PROLOG?

17 A. Yes.

18 Q. Was it involved with EPILOG?

19 A. Yes.

20 Q. You yourself were not involved with 14:51:14
21 EPIC?

22 A. That's correct.

23 Q. Were you involved with EPILOG?

24 A. I mean I was a fellow here at the
25 time EPIC was being done, but I wasn't on the 14:51:20

1 steering committee or on any type of
2 investigative committee.

14:51:24

3 Q. Were you involved with EPILOG as a
4 staff physician?

5 A. As a staff physician I would have
6 enrolled patients I believe in EPILOG, yes,
7 that would have been during that time. The
8 study I think was discontinued in December of
9 95, so yes.

14:51:31

10 Q. EPILOG was discontinued in December
11 of 95?

14:51:43

12 A. I think that's correct, yes.

13 Q. Do you know Dr. Cassandra Pileski?

14 A. I can't recollect that person.

15 Q. Apparently she is the referring
16 physician of Mr. Yurick.

14:51:59

17 A. Okay. So she's maybe a Kaiser
18 physician perhaps.

19 Q. Kaiser physician?

20 A. And hence I may not know her.

14:52:06

21 Q. You don't know if she's an employee
22 of Kaiser or of the Cleveland --

23 A. I do not.

24 Q. Or of the Cleveland Clinic
25 Foundation?

14:52:13

1 A. I do not know. 14:52:13

2 Q. Okay. To your knowledge, were any
3 Kaiser physicians involved in the care of
4 Mr. Yurick relative to his angioplasty on
5 January 15th of 96? 14:52:26

6 A. Could you repeat the question?

7 Q. To your knowledge were any Kaiser
8 physicians involved in the care of Mr. Yurick
9 on his admission of January 13th, 1996 relative
10 to his angioplasty? 14:52:39

11 A. Yes, I believe he was admitted to
12 the Kaiser service during that hospitalization,
13 yes. So he would have been cared for by Kaiser
14 physicians.

15 Q. During that admission, as part of 14:52:48
16 the cardiac catheterization and angioplasty
17 that was performed on Mr. Yurick, to your
18 knowledge would any Kaiser physicians have been
19 involved in those procedures?

20 A. I don't think so. I think I was 14:53:00
21 the physician who performed his catheterization
22 and angioplasty.

23 Q. Would any of those, would any
24 Kaiser physicians have been involved with the
25 post procedure care of Mr. Yurick following his 14:53:14

1 catheterization and angioplasty?

14:53:19

2 A. Yes.

3 Q. And in what way?

4 A. Not uncommonly, there is a primary
5 team caring for the patient, which may have
6 specialists also, and there may be the
7 proceduralist or the interventionalist, such as
8 myself, and we would each have participation in
9 his care.

14:53:28

10 Q. All right.

14:53:42

11 A. So they would not relinquish their
12 care, in other words, for him.

13 Q. We'll get into that in just a
14 little bit, but in general, after the cardiac
15 catheterization -- do you recall Mr. Yurick --

14:53:55

16 A. Of course.

17 Q. -- by the way? Do you recall the
18 procedures performed on January 15th, 96? The
19 catheterization and the angioplasty?

20 A. I have some recollection of them,
21 yes.

14:54:05

22 Q. All right. Following the
23 procedures, the records reflect that he was
24 then transferred to the general cardiology
25 floor?

14:54:15

1 A. To a cardiac telemetry floor where
2 interventional patients go, Kaiser and
3 nonKaiser patients.

14:54:16

4 Q. And he would have been monitored
5 during that stay there on the telemetry floor?

14:54:26

6 A. Yes.

7 Q. All right. To your knowledge,
8 would any Kaiser physicians have been involved
9 in his care while he was on the telemetry floor
10 post procedure?

14:54:38

11 A. Yes. I don't know to what degree.
12 I don't remember to what degree. But yes. So,
13 for example, they may have been called to see
14 him. We both have responsibilities, if you
15 will, for him, so some of which may have been
16 assigned to me and some to others.

14:54:56

17 Q. Okay. As far as residents or
18 fellows caring and treating for Mr. Yurick,
19 they would have been all residents and fellows
20 of the Cleveland Clinic Foundation?

14:55:11

21 A. That's correct.

22 Q. When did you yourself begin
23 utilizing ReoPro as a drug for angioplasties?

24 A. Soon after it was FDA approved.
25 How many days, I don't know. I mean certainly

14:55:30

1 I had used it, but in a blinded fashion, as you 14:55:38
2 asked earlier, in EPILOG, but in an open label
3 fashion, I would say days after it was FDA
4 approved.

5 Q. Roughly when was it FDA approved? 14:55:46

6 A. Good question. Maybe spring of 95.
7 I honestly don't remember. This was spring of
8 96. Yes, it had to be before Mr. Yurick's
9 procedure, I just don't remember when.

10 Q. Mr. Yurick's procedure was January 14:56:08
11 15th, 96. Can you give me an estimate of how
12 many cases, of how many angioplasty cases you
13 had done prior to Mr. Yurick where you utilized
14 ReoPro?

15 A. I don't, but I could find that 14:56:20
16 information for you in the database.

17 Q. Okay. If you could please do that
18 and then let your attorney know, then he can
19 give me that information.

20 MR. JONES: Sure. 14:56:29

21 Q. Okay. Once it was FDA approved,
22 somewhere in the spring of 95, as you
23 mentioned, what was your regimen as far as
24 utilizing ReoPro and heparin?

25 A. To the best of my recollection, as 14:56:48

1 it was FDA approved at the time.

14:56:49

2 Q. Do you recall the regimen or
3 protocol?

4 A. I mean I think it was a .25
5 milligram per kilogram for the bolus and ten
6 micrograms per kilogram for the infusion, but I
7 would have to look it up. I don't remember
8 what it was back then. But I think, as we have
9 talked about earlier, there was a standard
10 weight adjusted bolus and a standard nonweight
11 adjusted infusion, as was FDA approved and used
12 in the EPIC study.

14:56:56

14:57:13

13 Q. So following FDA approval, you
14 could have used standard dose heparin or low
15 dose weight adjusted heparin?

14:57:28

16 A. Well, the only data we had at that
17 time was EPIC.

18 Q. All right. I guess I'm looking for
19 an answer to my question, though. Following
20 FDA approval, would you have used standardized
21 heparin as well as weight adjusted low dose
22 heparin?

14:57:41

23 A. Yes.

24 Q. Prior to Mr. Yurick's angioplasty,
25 January 15th, 96, had you experienced patients

14:58:07

1 that developed intracerebral hemorrhage going 14:58:12
2 under angioplasty with ReoPro and heparin?

3 A. Could you repeat the question?

4 Q. Okay. Prior to Mr. Yurick's
5 procedure on January 15th, had you experienced 14:58:23
6 any patients prior to his procedure where you
7 had done angioplasty with ReoPro and heparin
8 that developed intracerebral hemorrhage?

9 A. I personally had not. We had the
10 cases that we talked about from the EPIC study, 14:58:41
11 so we knew that there was intracerebral
12 hemorrhage occurring in all three groups, and
13 it's a known risk with interventions in
14 general.

15 Q. Following FDA approval, you 14:59:04
16 mentioned you used ReoPro and heparin as part
17 of a regimen when you did angioplasties. Did
18 your protocol or regimen of ReoPro and heparin
19 in angioplasties ever change or be altered from
20 when you first started using it? 14:59:25

21 A. Could you repeat the question?

22 Q. Okay. I'm kind of confusing
23 myself.

24 From when you first started using
25 ReoPro and heparin as part of an adjunct in 14:59:33

1 your angioplasty procedures, have you ever 14:59:38
2 changed since that time your regimen and
3 protocol of ReoPro and heparin?

4 A. Yes.

5 Q. How have you changed it? 14:59:46

6 A. Following the publications of
7 EPILOG and the FDA's changing of the labeling
8 subsequently, ReoPro infusion is now weight
9 adjusted, as is the heparin dose, vascular
10 access sheaths are removed procedural and post 15:00:04
11 procedural heparin is not used unless
12 clinically necessary.

13 Q. I didn't hear the last part.

14 A. And post procedural heparin is not
15 used unless deemed clinically necessary. 15:00:17

16 Q. And what would be clinically
17 necessary? To use ReoPro?

18 A. Yes, I think nowadays a vessel that
19 cannot have or receive an intracoronary stent
20 where you still have residual concern for 15:00:30
21 thrombosis.

22 Q. And that protocol, you said you
23 yourself, changed following EPILOG and FDA
24 second approval; is that what you said?

25 A. I think the label was changed at 15:00:45

1 some point between EPIC and EPILOG. I don't 15:00:46
2 know exactly when.

3 Q. And EPILOG, I think you mentioned
4 earlier, was completed around 12-95?

5 A. Well, the enrollment. 15:00:58

6 Q. It was discontinued?

7 A. Enrollment was discontinued at the
8 recommendation of the DSMB, I think, in
9 December of 95.

10 Q. Has your regimen and protocol of 15:01:13
11 ReoPro and heparin as adjunct to your
12 angioplasty changed since your procedure on
13 Mr. Yurick?

14 MR. JONES: Objection. You can
15 answer. 15:01:25

16 A. It would be similar to the question
17 you just asked. EPILOG has been published
18 since Mr. Yurick's case and FDA has changed the
19 label since his case, so yes, by translation,
20 yes, I have changed since Mr. Yurick's case. 15:01:40

21 Q. So the studies of EPILOG were
22 published subsequent to Mr. Yurick's case?

23 A. Correct.

24 Q. How about the studies of EPIC?
25 Were they published prior to Mr. Yurick's case? 15:01:53

1 A. I believe so. It should be 15:01:58
2 referenced right in here. It was published in
3 the New England Journal in 1994.

4 Q. Have you utilized any other
5 glycoprotein IIb/IIIa inhibitors other than 15:02:11
6 ReoPro?

7 A. Yes.

8 Q. What have you used?

9 A. Integrilin, I N T E G R I L I N.
10 Tirofiban, T I R O F I B A N. Lamifiban, 15:02:24
11 L A M I F I B A N. Zemolifiban,
12 Z E M O L I F I B A N. I think that's it.

13 Q. Do you still use ReoPro?

14 A. Yes.

15 Q. These other inhibitors that you 15:02:46
16 mentioned, are they part of studies? Or
17 clinical trials?

18 A. I have used them both in part of
19 studies and since FDA approval of the other two
20 agents, which are FDA approved, tirofiban and 15:02:59
21 Integrilin.

22 Q. Intercerebral hemorrhage can occur
23 with the use of heparin?

24 A. Correct.

25 Q. It may occur with the use of 15:03:12

1 Coumadin? 15:03:14

2 A. Correct.

3 Q. May occur with the use of ReoPro?

4 A. Correct.

5 Q. What are the symptoms of 15:03:20

6 intracerebral hemorrhage?

7 A. I think they can be variable and

8 I'm not sure I could clearly distinguish the

9 symptoms as opposed to nonintracerebral

10 hemorrhage, stroke, but neurologic dysfunction, 15:03:38

11 so they would include perhaps a disorientation,

12 confusion, slurred speech, motor dysfunction,

13 things that would be neurologic in origin.

14 Q. Can they include headache?

15 A. Yes. 15:03:57

16 Q. Can they include nauseousness?

17 A. Yes.

18 Q. Can they include emesis?

19 A. Yes.

20 Q. Can they include elevated blood 15:04:02

21 pressure?

22 A. Probably, yes.

23 Q. Getting back to the regimen and

24 protocol, we talked about you utilizing ReoPro

25 and heparin, talked about the dosage and the 15:04:34

1 infusion, so forth. How, after the FDA
2 approval when you started utilizing ReoPro, how
3 did you monitor the anticoagulation effect pre,
4 during and post angioplasty procedure?

15:04:38

5 A. What anticoagulation effect?

15:04:54

6 Q. You would agree that ReoPro, in
7 combination with heparin, affects the
8 anticoagulation?

9 A. There are a number of measures of
10 anticoagulation, I just want to make sure. For
11 example, there is no readily available way to
12 monitor ReoPro's level of antiplatelet effect,
13 but I assume what you're asking is the level of
14 heparin effect in the cath lab.

15:05:03

15 Q. Okay. Heparin affects
16 anticoagulation?

15:05:22

17 A. Yes, a number of things do, like
18 Coumadin.

19 Q. Okay. Does not ReoPro affect
20 anticoagulation?

15:05:32

21 A. It affects platelet function, yes.

22 Q. Which in turn affects
23 anticoagulation?

24 A. It can to a degree. I have
25 published the papers showing it can affect some

15:05:43

1 measures of anticoagulation, and I'm not trying
2 to mince words here, but I just want to make
3 sure we are on the same wavelength here.

15:05:47

4 Q. Okay. But when you perform
5 angioplasties utilizing ReoPro and heparin in
6 combination, do you not want knowledge of the
7 patient's anticoagulation status?

15:05:58

8 A. Whenever you do any angioplasty,
9 you like to make sure you have a therapeutic
10 window of anticoagulation since you are
11 introducing risk for coagulation with
12 artificial devices, wires, balloons and such,
13 yes.

15:06:15

14 Q. As well as risks for bleeding?

15 A. Yes.

15:06:26

16 Q. As a result of using heparin and
17 ReoPro?

18 A. Yes.

19 Q. So --

20 A. As a result of using heparin. For
21 example, if you were to use ReoPro, if you
22 could imagine using ReoPro without heparin, you
23 may not measure level of anticoagulation
24 because there wouldn't be anything available to
25 measure.

15:06:30

15:06:48

1 Q. Okay. 15:06:51
2 A. I'm just trying to help.
3 Q. Yes. Hypothetically, if you were
4 using ReoPro --
5 A. Yes. 15:06:56
6 Q. -- would you expect your activated
7 clotting time to be affected?
8 A. (Nodding negatively.)
9 MR. JONES: Well, make sure you
10 answer out loud. You're shaking your head. 15:07:02
11 A. Sorry. I'm sorry. I would not
12 expect to see a significant change in the
13 activated clotting time with ReoPro alone in a
14 patient who has no heparin, right.
15 Q. Right. Would you expect in ReoPro 15:07:14
16 alone to see a change in the PTT?
17 A. I would not.
18 Q. Okay. A change, would you expect
19 using ReoPro alone to see a change in the PT?
20 A. I would not. 15:07:25
21 Q. Using ReoPro and heparin, would you
22 expect to see a change in the activated
23 clotting time?
24 A. From the heparin.
25 Q. Well, would you expect to see a 15:07:37

1 change in the ACT?

15:07:39

2 A. With heparin and ReoPro, yes. As
3 opposed to with no heparin and ReoPro.

4 Q. Would you expect to see a change,
5 with ReoPro and heparin, would you expect to
6 see a change in the PTT?

15:07:49

7 A. Yes.

8 Q. Would you expect to see a change,
9 using ReoPro and heparin, would you expect to
10 see a change in the platelet number?

15:08:02

11 A. Not necessarily.

12 Q. All right. Then let's get back to
13 my original question. When you are using
14 ReoPro and heparin in patients that you are
15 performing angioplasty on, do you want to
16 monitor the anticoagulation effect on a
17 patient?

15:08:18

18 A. You assess the activated clotting
19 time to make sure you are in desired clinical
20 window, yes.

15:08:35

21 Q. So you utilize activated clotting
22 time as part of your assessment?

23 A. Yes, part of routine angioplasty,
24 almost all patients would have a measure of
25 activated clotting time, in my practice.

15:08:50

1 Q. Would you also want to monitor the 15:08:52
2 PTT?

3 A. Not necessarily.

4 Q. Do you monitor the PTT --

5 A. Not necessarily. 15:08:58

6 Q. -- in your practice?

7 A. Not necessarily. Among patients
8 receiving heparin, they will have a measure of
9 anticoagulation, be it PTT or a surrogate.

10 Q. Or? 15:09:14

11 A. A surrogate. A whole blood assay
12 that is somewhere between an activated clotting
13 time and a PTT.

14 Q. Okay. And when would you assess
15 that? When would you monitor that? Prior to 15:09:25
16 the procedure?

17 A. So we're back to talking about
18 coronary interventions now. Okay?

19 Q. All right. Let me, what I'm trying
20 to get at is you mentioned that an angioplasty 15:09:37
21 where you use ReoPro and heparin, you want to
22 monitor the anticoagulation within a certain
23 window, okay? And you said one of the ways you
24 monitor that is through the activated clotting
25 time? 15:09:55

1	A. The only way in a cath lab is	15:09:57
2	through the activated clotting time, yes.	

3 Q. All right. And when do you monitor
4 the ACT?

5	A. At various times during the case.	15:10:10
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6 Q. Do you get an ACT preprocedure?

7 A. You'd have to define what the
8 procedure is.

9	Q. Angioplasty where you are using	
10	ReoPro and heparin.	15:10:51

11 A. You mean before the patient comes
12 to the cath lab or do you mean before the
13 balloon is inflated or do you mean --

14 Q. Before you have any invasive --

15	A. Not necessarily, no.	15:11:02
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16 Q. When would be the first time you
17 want to check an ACT?

18 A. When I was first hopeful that I
19 would be in the therapeutic window. So, for
20 example, before giving heparin, I wouldn't
21 bother to measure the ACT if I expected to see
22 no effect.

23 Q. Okay. This is getting a little --
24 let's do it this way, Doc. We're talking in
25 general, not just Mr. Yurick. Let's talk about 15:11:35

1 1996, when you were doing angioplasties using 15:11:45
2 ReoPro and heparin. Okay?

3 A. (Nodding affirmatively.)

4 Q. Prior to you initiating the
5 procedure, when would the patient be placed on 15:11:59
6 heparin?

7 A. After vascular access is obtained,
8 after a guiding catheter is found to be
9 satisfactorily in position, but before a
10 balloon inflation or a device was used to 15:12:13
11 manipulate the coronary plaque.

12 Q. Okay. So the patient wouldn't come
13 into the cath lab already on a heparin drip?

14 A. They should not be on a heparin
15 drip. 15:12:25

16 Q. Would they be bolused with heparin
17 prior to coming into the cath lab?

18 A. They should not be receiving
19 heparin from me until vascular access is
20 obtained. 15:12:36

21 Q. Okay. And when you say from me,
22 you mean the patient shouldn't be receiving
23 heparin at all?

24 A. Well, they may need to, it depends,
25 so for example, somebody comes from the 15:12:45

1 emergency room, they may be receiving heparin 15:12:48
2 if they are needing an emergency intervention.
3 I'm not trying to be obstinate here, but when
4 you ask me preprocedure, that could be, you
5 know, days or weeks before. 15:12:59

6 Q. But as part of your protocol, if
7 they are admitted with no heparin, the first
8 time you would give them heparin is after
9 vascular access was obtained?

10 A. That's correct. 15:13:14

11 Q. And how would you give the heparin?

12 A. Via intravenous bolus.

13 Q. Would it be weight adjusted?

14 A. In 1996? It might have been.

15 Q. If it was weight adjusted, what 15:13:33
16 dosage would you give? The 70 milligram per
17 kilogram?

18 A. The 70 units per kilogram would be
19 the best guess for 1996, yes.

20 Q. And then following the bolus, would 15:13:46
21 you give them an infusion?

22 A. I'm sure I did in some cases, I'm
23 sure I didn't in others, so I guess --

24 Q. Why in some cases you would and why
25 not in others? 15:13:59

1 A. For the same reason we use heparin 15:14:00
2 in any patient, to make them anticoagulated.

3 Q. How would you know if they were
4 anticoagulated?

5 A. By measuring a parameter of 15:14:11
6 anticoagulation.

7 Q. What parameter would you have
8 measured?

9 A. An ACT or a PTT or none at all,
10 depending on the level of anticoagulation that 15:14:24
11 we were using.

12 Q. So you would give them a bolus of
13 heparin once vascular access was obtained?

14 A. (Nodding affirmatively.)

15 Q. And then whether or not to continue 15:14:41
16 them on a heparin infusion would depend on
17 their anticoagulation state?

18 A. No, their need for further
19 anticoagulation. So for example, if there was
20 concern that maybe they needed ongoing heparin, 15:14:51
21 continued heparin.

22 Q. So how would you determine that?

23 A. I think it's a clinical adjustment
24 to decide if they have risk for thrombosis or
25 an event where you want the anticoagulant. 15:15:03

1 Q. So you wouldn't routinely check a 15:15:06
2 parameter such as PTT or ACT?

3 A. I would say that we would. It
4 depends on the extent of anticoagulation they
5 are given post procedure, the duration of 15:15:15
6 anticoagulation they are going to be given, so
7 for example, if somebody is only going to be on
8 anticoagulation for a short period of time, you
9 may not bother to measure it because by the
10 time this assay would come back, you would 15:15:25
11 already have decided to stop it and you
12 wouldn't act on that result, for example.

13 Q. We're talking about angioplasty
14 now, correct?

15 A. That's correct. But you were 15:15:39
16 speaking very generally and so I'm trying to
17 give you some general answers on what I did in
18 1996.

19 Q. I just don't understand why, if
20 you're doing angioplasty, why some people you 15:15:48
21 want short anticoagulation and some people you
22 want long anticoagulation.

23 A. Okay.

24 Q. Why is there a difference?

25 A. Not every patient is the same. Not 15:15:59

1 every patient needs heparin, some need more, 15:16:03
2 some people need less and some people need it
3 for shorter and greater duration of time.
4 That's what clinical medicine is about.

5 Q. Absent checking parameters, such as 15:16:14
6 ACT or PTT, can you tell clinically if a
7 patient is sufficiently anticoagulated?

8 A. I guess it depends by sufficiently.
9 I don't know what sufficiently, if somebody is
10 having, say, ongoing chest pain or recurrent 15:16:32
11 chest pain, you would be concerned that maybe
12 they're not adequately being anticoagulated,
13 that might be a suspicion for whether or not
14 they are sufficiently anticoagulated.

15 Q. All right. Well, let's narrow our 15:16:46
16 example down, then, to you are doing
17 angioplasty with somebody with unstable angina.

18 A. Yes.

19 Q. What type of anticoagulation would
20 you want on that type of patient? 15:16:57

21 A. In 1996? Somebody with unstable
22 angina?

23 Q. Uh-huh.

24 A. I think it's probably not
25 dramatically different among patients today, 15:17:05

1 they would receive intravenous heparin. 15:17:08

2 Q. So would you bolus them, once
3 vascular access was obtained?

4 A. Now we're talking about
5 intervention. 15:17:15

6 Q. Right. As part of your procedure.
7 Your angioplasty procedure.

8 A. So all angioplasty patients are
9 going to receive heparin. Unstable angina or
10 not. 15:17:25

11 Q. They are going to receive a bolus
12 after vascular access is obtained?

13 A. Yes.

14 Q. Okay. Thank you. In patients with
15 unstable angina that are undergoing your
16 angioplasty, are you going to then give them an
17 infusion of heparin following the bolus? 15:17:32

18 A. Not necessarily.

19 Q. All right. And again, it
20 determines whether or not you think they are
21 sufficiently anticoagulated? 15:17:48

22 A. Depending on whether or not there's
23 a clinical need for ongoing anticoagulation.

24 Q. All right. If you think there is,
25 you would check a parameter to make sure they 15:17:57

1 are within the window of anticoagulation? 15:18:01

2 A. Yes, as you asked before, I may or
3 I may not, it depends, again, on the duration,
4 the strength of the coagulation, et cetera.

5 Q. And if you did check a parameter, 15:18:12
6 one of the parameters would be ACT?

7 A. Correct.

8 Q. And what would be an acceptable
9 value for you as far as the ACT is concerned
10 relative to acceptable anticoagulation? 15:18:21

11 A. It depends on the clinical context.
12 So as I told you, some patients you may not
13 monitor it in. We have, for example, here in
14 1999 several ranges of PTT that we shoot for in
15 patients, you know, kind of a low, medium, a 15:18:37
16 high therapeutic, so I think it goes according
17 to clinical scenario.

18 Q. Okay.

19 A. If you're talking about
20 heparinization of patients with infusions. 15:18:46

21 Q. All right. Let's go back to 1996.
22 We're doing angioplasty using ReoPro and
23 heparin on a patient with unstable angina.

24 A. Uh-huh.

25 Q. And as we mentioned, as you 15:18:57

1 mentioned, once vascular access is obtained, 15:19:00
2 you bolus them with heparin. All right. For
3 this example let's say you want to continue
4 heparin infusion.

5 A. After the procedure? 15:19:10
6 Q. No, during the procedure, but after
7 the bolus.

8 A. Okay.
9 Q. Okay? So you're going to bolus
10 them and then start a heparin drip. 15:19:18
11 A. I may.

12 Q. All right. For this for example I
13 am saying you are.

14 A. Okay. Thank you.

15 MR. JONES: The hypothetical, 15:19:26
16 obviously.

17 A. Thank you. Got it. Thank you.

18 Q. All right. You bolus them and then
19 you start a heparin drip. During the
20 procedure, okay, are you going to check a 15:19:38
21 parameter, either ACT or PTT?

22 A. I may.

23 Q. And when would you not?

24 A. If I thought I was going to
25 discontinue the infusion or the infusion was at 15:19:46

1 such a low rate that I didn't think it was 15:19:49
2 going to be meaningful to check, so whether or
3 not I was going to use the information would be
4 whether or not I would request it. So for
5 example, if I thought I was going to stop the 15:19:58
6 infusion soon thereafter, so that it didn't
7 matter the result, I may not have checked it.

8 Q. How about if you were going to
9 continue the infusion post procedure?

10 A. It depends for what length of time 15:20:11
11 which I was going to continue it. As I said
12 before, it might take, for example, four to six
13 hours to get a PTT back from a laboratory, and
14 if I knew in my mind I was only going to
15 continue the heparin for a shorter duration, I 15:20:22
16 may not have requested a PTT because by the
17 time the results would have returned, we would
18 have already had the decision to stop it, so it
19 wouldn't have affected our management.

20 Q. Now, we prefaced all this by saying 15:20:33
21 you are using ReoPro and heparin in
22 combination, correct?

23 A. Okay.

24 Q. All right. Let's go back to the
25 beginning, doing a angioplasty, you would bolus 15:20:42

1 them with heparin after vascular access is 15:20:48
2 obtained. When would you first give them
3 ReoPro? We're talking 1996 now.

4 A. Well, they were given at the same,
5 they were given very close to the same time, 15:21:00
6 heparin and ReoPro would be given nearly the
7 same time, within minutes of each other.

8 Q. So you would give ReoPro after the
9 vascular access is obtained as well?

10 A. Correct. 15:21:13

11 Q. As a bolus?

12 A. Correct.

13 Q. Would you continue ReoPro as an
14 infusion after the bolus is given?

15 A. Yes. 15:21:21

16 Q. How long would you continue the
17 ReoPro infusion?

18 A. In 1996, for 12 hours.

19 Q. Okay. And then you would
20 discontinue it? 15:21:42

21 A. Yes.

22 Q. And the heparin, as you mentioned
23 earlier, is variable depending on whether you
24 feel they need to be anticoagulated or a short
25 time or a long time? 15:21:53

1	A.	Correct.	15:21:55
2	Q.	Let's talk about Mr. Yurick	
3		specifically, now. Were you involved in his	
4		care at all on October 17th, 1995?	
5	A.	Not to my knowledge.	15:22:39
6	Q.	You have his records in front of	
7		you. In October, on October 17th, 95	
8		Mr. Yurick had a angioplasty performed here at	
9		the clinic?	
10	A.	Okay.	15:22:52
11	Q.	First diagonal branch of the LAD.	
12		Do you know if ReoPro was utilized during that	
13		procedure?	
14	A.	I do not believe so.	
15	Q.	Do you know if he developed any	15:23:02
16		major bleeding after that procedure?	
17	A.	I do not know.	
18	Q.	When was your first involvement	
19		with the care of Mr. Yurick?	
20	A.	I don't know. I believe it was	15:23:18
21		obviously before his intervention in January of	
22		96.	
23	Q.	The admission of January 13th, 96?	
24	A.	Yes.	
25	Q.	Do you know what his diagnosis was?	15:23:39

1 A. When? 15:23:43

2 Q. When he was admitted on January

3 13th, 1996.

4 A. Yes.

5 Q. What was it? 15:23:47

6 A. Unstable angina.

7 Q. Relative to his angioplasty of

8 October 17th, 95, do you have any knowledge of

9 whether that procedure, during that procedure

10 Mr. Yurick was involved in any clinical trials? 15:24:00

11 A. I don't know.

12 Q. Relative to his angioplasty on

13 January 15th, 96, was that part of any clinical

14 trial?

15 A. Not to my knowledge. 15:24:13

16 Q. If it was, you would have had

17 knowledge, correct?

18 A. I don't know if he was in other

19 clinical trials before or not. Not to my

20 knowledge. I mean if he was in a lipid 15:24:23

21 lowering trial or something like that, not to

22 my knowledge.

23 Q. Let me be more specific. To your

24 knowledge, when you did the angioplasty on

25 January 15th, 96, was Mr. Yurick involved in 15:24:33

1 any clinical trials studying the drug ReoPro? 15:24:36

2 A. No.

3 Q. Same question relative to

4 angioplasty on October 17th, 95?

5 A. Not to my knowledge. 15:24:46

6 Q. Do you have the interventional

7 report, procedure report? I'd like to just go

8 through that.

9 A. Which do you mean?

10 Q. I'm sorry, the interventional 15:25:04

11 procedure report of 1-15-96.

12 A. Do I have this?

13 Q. Yes.

14 A. Probably, yes.

15 Yes, I have that. 15:25:20

16 Q. Is it the same as this?

17 A. Yes, same date.

18 Q. Prior to doing the angioplasty, you

19 performed a catheterization?

20 A. Yes. 15:25:39

21 Q. Cardiac catheterization. Did you

22 have any cardiology fellow with you to assist

23 you?

24 A. Yes.

25 Q. Who was that? 15:25:49

1 A. Should be listed in the report. I 15:25:52
2 believe his name was Jason Wischmeyer.

3 Q. There's a Sorin Brenner.

4 A. He would have done the dictations.
5 Interventional fellow does the dictations. But 15:26:05
6 there is a diagnostic fellow who would
7 relinquish his dictating responsibilities to
8 the interventional fellow. I thought his name
9 was Jason Wischmeyer for the diagnostic
10 catheterization. 15:26:22

11 Q. Wischmeyer.

12 A. Yes. Thanks. It's on this right
13 here.

14 Q. Okay. But the interventional
15 fellow would have been Sorin Brenner? 15:26:34

16 A. Dr. Brenner, that's correct.

17 Q. Who performed the cardiac
18 catheterization?

19 A. I did.

20 Q. And what was your finding? 15:26:37

21 A. A severe narrowing in the, it's
22 listed here at 80 percent stenosis in the first
23 diagonal branch.

24 Q. Was that the same area where he had
25 the stenosis in October of 95? 15:26:52

1 A. Yes.

15:26:57

2 Q. And then based on the
3 catheterization results and findings, you
4 decided to perform an angioplasty --

5 A. Correct.

6 Q. -- of that lesion?

7 A. Correct.

8 Q. Why did you decide to use ReoPro
9 for the angioplasty?

10 A. Because he had unstable angina and
11 because of the results of the EPIC trial.

15:27:33

12 Q. Okay. When was Mr. Yurick first
13 given ReoPro?

14 A. After vascular access was obtained
15 and the equipment was put in position for his
16 coronary intervention.

15:27:56

17 Q. Is that noted on the records?

18 A. I'm sure it is.

19 MR. JONES: You have to get out
20 this one we missed. The record I just gave
21 him, Doctor, which should be in the front of
22 the chart now.

15:28:05

23 THE WITNESS: Sure. Or we can look
24 at it on the order sheets.

25 MR. JONES: Or on the order sheets.

15:28:16

1 Q. The physician orders? 15:28:19

2 A. Yes, it should be listed in the

3 physician orders. I'm sorry, you said you put

4 them in front.

5 MR. JONES: Yes, I have, the one we 15:28:29

6 got. No, that's not --

7 MR. FINELLI: That's a physician

8 order.

9 MR. JONES: Yeah, that's an order

10 to bring it. But you asked when it was given. 15:28:37

11 A. That's not when it was given.

12 Q. I just want to know when it was --

13 A. When it was given.

14 Q. How about this order? It says it's

15 given at 11:40. 15:28:50

16 MR. JONES: Uh-huh, that's correct.

17 A. Yes, 11:40.

18 Q. Is that located, noted in the lab

19 flow sheet?

20 A. Yes. 15:28:58

21 Q. Okay. ReoPro --

22 A. At 11:40, right.

23 Q. How many milligrams?

24 A. Looks like 8.2.

25 Q. As a bolus? 15:29:10

1 A. That's correct. 15:29:11

2 Q. Is there any documentation of when

3 vascular access was obtained?

4 A. Yes, it would be in perhaps the

5 report. Looks like 10:45, but we can -- 15:29:25

6 MR. JONES: What are you looking

7 for?

8 THE WITNESS: Oh, that one sheet

9 where it says I obtained access. Looks like

10 10:40. 15:29:37

11 Q. Okay. And where would that be?

12 A. I'm sorry.

13 Q. Would that be over here?

14 A. Yes. Thanks.

15 MR. JONES: It's also here. 15:29:44

16 A. Yes, it's on both, it's both in

17 this record and in that record here.

18 Q. So ReoPro was given an hour after

19 vascular access?

20 A. Yes. 15:29:56

21 Q. As a bolus?

22 A. Yes.

23 Q. Did the patient come to the cath

24 lab already on heparin?

25 A. No. 15:30:06

1 Q. When was heparin first given? 15:30:07

2 A. When he was admitted to the
3 hospital, I believe. On January -- I think I
4 saw it in the admission orders.

5 Q. Strike that. I mean what I meant 15:30:19
6 to say was when was heparin first given as part
7 of the procedure, your procedure?

8 A. Okay.

9 Q. There's a notation of 11:42. I
10 don't know if that's the first. 15:30:48

11 A. Yes, thank you, 11:42. That does
12 help.

13 Q. 11:42?

14 A. Yes.

15 Q. So he would not have arrived with 15:31:00
16 the heparin drip to the cath lab?

17 A. Correct.

18 Q. And you gave a bolus of 5,000
19 units?

20 A. Yes. 15:31:08

21 Q. IV? All right. And then
22 subsequent to that or simultaneous with that
23 you began a ReoPro drip?

24 A. Correct.

25 Q. And what was the dosage of the 15:31:19

1 ReoPro? I can't read that. 15:31:21

2 A. That's the standard, the standard

3 dose of ten.

4 Q. Micrograms per kilogram?

5 A. Uh-huh. No, per minute, it was not 15:31:33

6 kilogram. It wasn't weight adjusted, it was

7 just a standard infusion.

8 Q. Ten microgram per minute?

9 A. Thank you. Yes. So for 720

10 minutes or 12 hours, yes. 15:31:43

11 Q. Okay. Following the heparin bolus,

12 was he placed on heparin infusion?

13 A. Not to my knowledge.

14 Q. And then following that flow sheet,

15 at 11:51 it appears that an ACT was obtained of 15:32:11

16 286?

17 A. Uh-huh.

18 Q. Why did you obtain an ACT in this

19 patient?

20 A. As we talked about previously, to 15:32:24

21 assess the extent of anticoagulation.

22 Q. The 286, was this a comfortable

23 window of anticoagulation?

24 A. No, in 1996, as you know with EPIC,

25 the ACT was most often in the high 300s, 15:33:00

1 whether with or without heparin, and so our
2 target then would have been in the 350 range
3 for coronary intervention.

15:33:04

4 Q. So based on that ACT of 286, you
5 feel he was not sufficiently anticoagulated?

15:33:21

6 A. Correct.

7 Q. Did you do anything to give him
8 anything for more anticoagulation?

9 A. Well, first we -- yes, we did. But
10 at that same time he was developing chest pain
11 with electrocardiographic changes and that in
12 combination with his ACT of 286, he was given
13 an additional 2,000 units of heparin
14 intravenously.

15:33:40

15 Q. As a bolus?

15:33:55

16 A. As a bolus, yes.

17 Q. That would have been when, around
18 11 -- before 11:59?

19 A. Correct. Sometime after the ACT of
20 286.

15:34:03

21 MR. FINELLI: Off the record for a
22 second.

23 (Discussion had off the record.)

24 Q. Doctor, I'm showing you this flow
25 sheet here where there's some writing, again

15:36:11

1 there's a timetable, where it has the ACT of 15:36:14
2 286. To your knowledge this was, this record
3 here, this sheet was produced at the same time
4 these other records were produced, January
5 15th, 96? 15:36:25
6 A. Yes.
7 Q. All right. So following the ACT of
8 286, you wanted to increase his anticoagulation
9 so you gave him an additional bolus of heparin,
10 2,000 units? 15:36:38
11 A. Yes.
12 Q. At any time during the procedure
13 did you adjust the ReoPro --
14 A. No.
15 Q. -- infusion? 15:36:48
16 At any time after that heparin of
17 2,000 units was given, did you give him any
18 more heparin?
19 A. No.
20 Q. Either bolus or infusion? 15:36:57
21 A. Not to my knowledge, no.
22 Q. So that would have been the last
23 heparin he would have received?
24 A. Yes.
25 Q. That 2,000 units, somewhere right 15:37:04

1 before 11:59? 15:37:07

2 A. Correct.

3 Q. It appears on the next page,
4 following that catheterization flow sheet, an
5 ACT was obtained around 12:10? 15:37:17

6 A. Correct.

7 Q. Timewise.

8 A. Yes.

9 Q. And the ACT level was 374?

10 A. Yes. 15:37:26

11 Q. Any concern to you regarding his
12 anticoagulation with that level?

13 A. No.

14 Q. Why was that ACT obtained?

15 A. Because the 2,000 units more of 15:37:41
16 heparin were given.

17 Q. Did you feel, based on that level,
18 that Mr. Yurick was within an acceptable window
19 of anticoagulation?

20 A. Yes. 15:37:58

21 Q. Looking at the cardiac
22 catheterization lab notes now.

23 A. Okay.

24 Q. About halfway down on the left-hand
25 column there appears to be a notation reading 15:38:37

1 ACT check 4 p.m.? That would be right there, I 15:38:40
2 think.

3 A. Thanks. Yes.

4 Q. Okay? If no additional heparin was
5 given after the 2,000 units, why would an ACT 15:38:50
6 level need to be checked at 4 p.m.?

7 A. To be certain, it was safe to
8 remove his vascular access.

9 Q. So other than the 7,000 units of
10 heparin that was given prior to noon on January 15:39:36
11 15th, Mr. Yurick received no further heparin?

12 A. Not to my knowledge, no.

13 Q. Other than the two ACTs that were
14 obtained, did you obtain any PTTs?

15 A. Not to my knowledge, no. 15:40:38

16 Q. Did you check any platelet counts
17 during the procedure or after the procedure?

18 A. Not during the procedure, but quite
19 likely after the procedure, yes.

20 Q. When would they have been checked? 15:40:57

21 A. I don't know. I can look and see.
22 Exact interval, usually it's done hours
23 thereafter.

24 Q. You're not stating that relative to
25 when he develops his neurological problems? 15:41:08

1 A. (Nodding negatively.) It's just 15:41:15
2 unclear to me when in current protocols and
3 what I would remember now, we check platelets
4 usually two hours into the infusion of ReoPro,
5 and whether or not that protocol was in place 15:41:20
6 at this time I don't know. But it's pretty
7 standard to check platelet counts subsequent to
8 coronary intervention with ReoPro. But to my
9 knowledge he never had an abnormal platelet
10 count. 15:41:40

11 Q. When did you first become aware --
12 strike that.

13 When did the angioplasty procedure
14 finish?

15 A. When did he leave the procedure 15:42:23
16 room?

17 Q. When did you complete the
18 procedure?

19 A. According to the notes, it says
20 somewhere around 1305 completed procedure. So 15:42:39
21 somewhere around 1305, according to that
22 record. 1306 maybe on that one. Here the
23 patient looks like they are leaving the room at
24 1330.

25 Q. Looking at the catheterization lab 15:43:14

1 notes and flow sheets. 15:43:16

2 A. Okay.

3 Q. In reviewing those now, do you find

4 anything abnormal relative to his

5 anticoagulation? 15:43:27

6 A. No.

7 Q. Anything abnormal relative to the

8 procedure itself?

9 A. No.

10 Q. Anything relating to complications 15:43:37

11 developed?

12 A. Not to my knowledge.

13 Q. I've been handed prior to the

14 deposition a computer printed flow sheet. At

15 the top it says cardiac catheterization report, 15:44:17

16 Martin Yurick, date 1-15-96?

17 A. Yes.

18 Q. When would this have been

19 generated?

20 A. During the procedure. 15:44:31

21 Q. You were looking at the original?

22 A. Yes.

23 MR. JONES: I'm going to object. I

24 mean it's a computer record. There is no hard

25 copy or original per se. It's all on a 15:44:44

1 computer. We copied it, we copied this off 15:44:47
2 just before we came down here.

3 Q. Okay. I'm going to have you look
4 at the physician orders just quickly. He's
5 admitted on 1-13-96, at the bottom it says 15:45:13
6 consult Kaiser cardiology.

7 A. Yes.

8 Q. Possible cath. Was there, to your
9 knowledge, was there any cardiologist from
10 Kaiser involved in Mr. Yurick's care during 15:45:22
11 this admission?

12 A. During this hospitalization?

13 Q. Correct.

14 A. During this hospitalization, yes.

15 Q. Of 1-13-96? 15:45:32

16 A. During this hospitalization, yes.

17 Q. Who would that have been?

18 A. I have to refer to the chart.

19 On 1-13-96 he was seen by Dr. Ann
20 Mostow, M O S T O W. 15:46:05

21 Q. Let me just get that. Is that in
22 the clinic sheet section?

23 A. It is. It looks like it's on the
24 second page of his. It looks like this.

25 There. 15:46:24

1 Q. Okay. Dr. Mostow you said? 15:46:25
2 A. Yes.
3 Q. Is that a male or a female?
4 A. It's a woman.
5 Q. Kaiser cardiologist? 15:46:32
6 A. Correct.
7 Q. Did you have any discussions with
8 her relative to Mr. Yurick's care?
9 A. Yes.
10 Q. And do you recall the conversation 15:46:44
11 at all?
12 A. No.
13 Q. What would be the purpose of
14 Dr. Mostow evaluating Mr. Yurick?
15 A. Came in with a cardiac related 15:46:55
16 problem and a consultation was made to
17 cardiology and she responded to that
18 consultation.
19 Q. Did Dr. Mostow feel that Mr. Yurick
20 needed catheterization, cardiac 15:47:07
21 catheterization?
22 A. I presume so. It says that she
23 explained the risks and benefits of a cath and
24 possible intervention, so I assume that that
25 was her belief. 15:47:19

1 Q. And that's probably why you were 15:47:20
2 referred or consulted?
3 A. Yes.
4 Q. Dr. Mostow didn't have any
5 participation in the cardiac catheterization or 15:47:26
6 angioplasty?
7 A. No.
8 Q. Looking in the physician orders,
9 post coronary intervention orders.
10 A. Okay. 15:48:06
11 Q. Under heparin protocol. Are you
12 with me?
13 A. Yes.
14 MR. JONES: That's it.
15 Q. Okay. Are these orders orders that 15:48:32
16 are initiated once the patient returns to the
17 telemetry unit?
18 A. Yes.
19 Q. What was the heparin protocol
20 orders? 15:48:45
21 A. Says the activated clotting time
22 was to be checked at 1600 hours.
23 Q. We discussed that earlier.
24 A. Just reading through those orders.
25 Q. Sure. 15:49:05

1 A. Now, it says to notify the nurse if 15:49:06
2 it's below that and the sheath would be
3 removed. Two hours after that he was to be
4 rebolused with a thousand units of heparin and
5 to be maintained at a drip of 600 units per 15:49:15
6 hour until 6 a.m. the following morning. If he
7 was free of chest pain, it were to be
8 discontinued then.

9 Q. All right. So he was to be
10 rebolused with heparin at a thousand units and 15:49:29
11 then started on a drip, heparin drip?

12 A. That's correct.

13 Q. All right. When was that supposed
14 to start?

15 A. Two hours after the sheath was 15:49:39
16 removed and adequate hemostasis was obtained.

17 Q. And looking further down, sheath
18 removal protocol, when would the sheath, when
19 was the sheath ordered to be removed?

20 A. When adequate, when adequate 15:49:53
21 lowering of the activated clotting time
22 occurred. The first assessment would have been
23 at 1600 to see if you are low enough to remove
24 it.

25 Q. What would have been an acceptable 15:50:03

1 range of the ACT to allow the sheath to be 15:50:05
2 removed?

3 A. I think at that time it had to be
4 under 175.

5 Q. So prior to 4 o'clock the sheath 15:50:14
6 would not have been removed?

7 A. That's correct.

8 Q. And therefore he would not have
9 been given any heparin prior to 4 p.m., 1600
10 hours? 15:50:24

11 A. Right, the minimum should have been
12 greater than 1800, plus the amount of time it
13 took to obtain hemostasis, so it wouldn't have
14 been till maybe 1830 at the minimum.

15 Q. Looking further down in the order 15:50:49
16 sheets, if we're looking at 1-15-95 at 4:25
17 p.m.?

18 A. Yes.

19 Q. There's an order to DC ReoPro?

20 A. Yes. 15:51:02

21 Q. Was that when the ReoPro would have
22 been discontinued?

23 A. Well, it may have been stopped
24 sooner than that. But this was when the order
25 was written. Perhaps the physician had it 15:51:10

1 stopped and then wrote the order subsequent to 15:51:13
2 that. Because of the nature of the case.

3 Q. All right. We're looking again at
4 1-15-96 where he's admitted to MICU?

5 A. Yes. 15:51:25

6 Q. There's an order to transfuse
7 platelets, about two-thirds of the way down?

8 A. Yes. Yes.

9 Q. Prior to this order, was Mr. Yurick
10 given any platelet transfusion? 15:51:40

11 A. I don't know. I'll look and see.

12 It looks like on the previous page
13 that you had talked about, it says 14 units
14 platelets ASAP. Here. It looks likes that
15 says 14 units of platelets as soon as possible. 15:52:02

16 Q. That would have been at 4:25 p.m.,
17 as written?

18 A. Yes.

19 Q. When did you first become aware of
20 Mr. Yurick's neurological problems, post 15:52:27
21 angioplasty?

22 A. Sure. Somewhere around 4 p.m. on
23 January 15th.

24 Q. And what note do you have? The one
25 where you cosigned? 15:53:06

1 A. Yes. 15:53:08

2 Q. From, looks like an R.N., May?

3 A. Yes. So somewhere around there,

4 it's unclear when I would have known they were

5 to be neurologic, but that obviously developed 15:53:18

6 over the ensuing minutes.

7 Q. You cosigned this note, correct?

8 A. Yes.

9 Q. 1-15 at 4 p.m.?

10 A. But I'm not sure whether it was 15:53:33

11 clear then, your question was whether or not I

12 was aware of a neurologic, but it's just

13 unclear exactly timewise, but I just noted that

14 as being around 4 p.m., but I'm not sure

15 exactly when during that it was deemed to be 15:53:39

16 neurologic.

17 Q. Just so I'm clear --

18 A. Yes.

19 Q. -- your cosignature here would have

20 been placed when? Subsequent to this note 15:53:46

21 being written at 4 p.m., correct?

22 A. Yes, a cosignature would be on top

23 of another signature, right.

24 Q. So from what I'm understanding, at

25 4 p.m. you were aware of this situation going 15:54:00

1 on? Or were you not?

15:54:02

2 A. At 4 p.m. it looks like the note
3 was written, but I'm not certain relative to
4 how many minutes before or after I would have
5 been aware.

15:54:12

6 Q. Would this Nurse B. May here, would
7 she have contacted you as part of writing this
8 note?

9 A. Yes.

10 Q. So sometime around 4 p.m. you would
11 have been aware of the patient's complaints?

15:54:30

12 A. That's correct.

13 Q. And the patient's complaints, based
14 on this note, were nausea? Nausea, right?

15 A. Yes.

15:54:47

16 Q. And emesis?

17 A. Yes.

18 Q. And elevated blood pressure?

19 A. Well, his complaint was nausea, but
20 at the same time he was found to have elevated
21 blood pressure, yes.

15:54:55

22 Q. This is an R.N. writing this note,
23 correct?

24 A. Correct.

25 Q. And an EKG was obtained? Who would

15:55:12

1 have ordered the EKG?

15:55:16

2 A. Well, I would have ordered it
3 through Barbara May.

4 Q. And apparently, according to this
5 note, there were no acute changes?

15:55:26

6 A. Correct.

7 Q. Based on this information that she
8 relayed to you sometime around 4 p.m., did you
9 have any concerns regarding Mr. Yurick's
10 condition?

15:55:41

11 A. Yes.

12 Q. What were you concerned about?

13 A. Well, that he was still nauseated,
14 as he had been before the intervention, during
15 the intervention, and now after the
16 intervention, so that would have been my
17 concern. In addition, to make sure he wasn't
18 having any cardiac or other problems.

15:55:50

19 Q. And based on the EKG, it did not
20 appear he was having any cardiac problems?

15:56:05

21 A. Correct.

22 Q. Why were you concerned about his
23 nausea?

24 A. Just because we don't like patients
25 to be nauseated.

15:56:12

1 Q. Did you develop any differential as 15:56:16
2 to why he was nauseous?

3 A. I don't remember, but I'm sure I
4 did. I mean I don't know exactly what the
5 differential was, but certainly a concern was 15:56:28
6 that he had ongoing cardiac problems since his
7 presenting symptom was nausea. At the time of
8 previous procedures he had nausea. I think in
9 October of 95, for example, he had nausea,
10 so -- 15:56:44

11 Q. As a result of his --

12 A. Unstable angina.

13 Q. -- unstable angina? So as a result
14 of that, were you concerned that he may be
15 restenosing? 15:56:54

16 A. Not restenosis, but having
17 threatened closure of the artery.

18 Q. Ischemia?

19 A. Yes, ischemia, thanks.

20 Q. Were you concerned about bleeding? 15:57:04

21 A. No, but that would be in the
22 differential for causing nausea. Some people
23 do get nausea with bleeding.

24 Q. And they can get nausea with
25 intracerebral bleeding? 15:57:18

1 A. Well, I was thinking of
2 retroperitoneal because intracerebral is so
3 rare, but nausea is such a nonspecific
4 complaint.

5	Q. Okay.	15:57:29
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6 A. Especially since he had had it
7 before the procedure.

8 Q. What was done as a result of those
9 complaints at 4 p.m.?

10	A. Well, the --	15:57:36
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11 Q. Besides the EKG?

12 A. The assessment was made.

13 Q. By whom?

14	A. By Barbara May and myself, and I	
15	see, as we discussed, the EKG was ordered and	15:57:44
16	assessed.	

17 Q. Did you, when you say you assessed
18 him, did you assess him physically in person --

19 | A. Yes.

20	Q. -- or over the phone?	15:57:52
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21 A. Physically in person.

22 Q. So you were there to see him in the
23 room?

24 A. Maybe not exactly at this time, but
25 somewhere in this time, yes. 15:58:02

1 Q. Okay. 15:58:04

2 A. But exactly when I was called and
3 when I saw him relative to this note writing, I
4 can't say for certain. I can try to discern
5 that for you, if you want. I can't give you an
6 exact time. 15:58:15

7 Q. Other than those two signatures on
8 that page --

9 A. Yes.

10 Q. -- correct me if I'm wrong, your
11 next signature, accompanied by your note, is
12 1-15-96 at time 2010? 15:58:34

13 A. Yes.

14 Q. Which would be 8:10 p.m.?

15 A. Right. 15:58:50

16 Q. So are you saying around this time,
17 4 p.m., give or take, what, 30 minutes, you
18 would have seen Mr. Yurick?

19 A. I can't say the give or take, but
20 around that time I saw him, but the time with
21 which I wrote a note wasn't of importance to me
22 at that time, you know, seeing him and taking
23 care of him and then writing a note later was. 15:59:01

24 Q. Sure.

25 A. Sure. 15:59:15

1 Q. The next note is written at 4:10. 15:59:27
2 I think it's by the same lady, Miss May?
3 A. Yes.
4 Q. And you cosigned that as well?
5 A. Correct. 15:59:38
6 Q. And that is because she is called
7 because of an elevated blood pressure reading
8 from the A line?
9 A. Yes.
10 Q. He's given Procardia. Is that 15:59:46
11 ordered by you?
12 A. Yes.
13 Q. Any concerns regarding the elevated
14 blood pressure?
15 A. Yes, that's why he received the 15:59:54
16 Procardia.
17 Q. So you are treating the elevated
18 blood pressure with the Procardia. Did you
19 have any concerns about why the elevated blood
20 pressure? 16:00:05
21 A. Sure.
22 Q. Those were what?
23 A. I don't remember, but I think I can
24 just speak generally, since it's now been
25 several years, but people have elevated blood 16:00:22

1 pressure, you don't want them to develop into
2 ischemia or bleeding perhaps, so you try to
3 lower the pressure.

16:00:24

4 Q. Based on these records, when was it
5 determined or considered that Mr. Yurick was
6 developing an intracerebral bleed or
7 hemorrhage?

16:00:47

8 A. Well, I don't know if I can answer
9 that specifically, but I can say that concern
10 at 4:15 for neurologic abnormality, because he
11 was then confused, at least by these notes and
12 times, I would say is when I would first be
13 concerned about neurologic dysfunction.

16:01:01

14 Q. At 4:15?

15 A. Yes.

16:01:17

16 Q. Based on the note --

17 A. This is a time the note was
18 written, but whether it was 412 or 414 or 416 I
19 can't quite say for certain.

20 Q. And who wrote that note?

16:01:26

21 A. The assumption would be Barbara
22 May, but it's not signed.

23 Q. Okay. I just want to look at the
24 original document.

25 A. Sure.

16:01:37

1 Q. As you can see, my copy's not good. 16:01:37

2 A. I agree.

3 Q. 4:15, you agree that it states
4 patient became confused, not responding
5 appropriately to verbal commands, check CBC, 16:01:44
6 call Dr. Brenner for his assessment. Correct?

7 A. That's correct.

8 Q. Okay. Why would you not have been
9 called if you were called earlier?

10 A. She may have known that I was 16:01:57
11 unavailable doing, I don't remember, another
12 catheterization or maybe perhaps speaking to
13 the family or just not available as quickly
14 perhaps as she knew Dr. Brenner was. And then
15 on the side I noticed that it says ACT, oh, I'm 16:02:08
16 sorry, Accu-Chek, I can't say what this is, ACT
17 106.

18 Q. I don't know if that's a -- is that
19 an ACT?

20 A. I don't know, to be honest. Maybe 16:02:19
21 an Accu-Chek because they are worrying about
22 glucose perhaps.

23 Q. That's at 4:15. At 4:20 there's a
24 note, patient became obtunded approximately
25 fifteen to twenty minutes ago? 16:02:30

1 A. Yes. 16:02:33
2 Q. Had emesis prior to this time?
3 A. Yes.
4 Q. And you cosigned that as well?
5 A. Yes. 16:02:43
6 Q. Do you know who that was written
7 by?
8 A. Sorin Brenner.
9 Q. That would have been your
10 interventional fellow? 16:02:47
11 A. Correct. Looks like two
12 different -- looks like I came and left again
13 because there's a different ink pen when I
14 signed that.
15 Q. Okay. Between the time that 16:03:00
16 Mr. Yurick arrives at the telemetry floor from
17 his angioplasty to 4:15, that interval of time,
18 looking through the notes, are there any Kaiser
19 physicians that evaluate Mr. Yurick?
20 A. We could look at nurses notes, but 16:03:21
21 I don't see any Kaiser physician writing here,
22 but whether or not they evaluated and didn't
23 leave a note, we could look at perhaps the
24 nurses bedside notes. She may or may not have
25 mentioned who came and left the room. 16:03:33

1 Q. Actually the note 1-15-96, 4 p.m. 16:03:48
2 appears to be the first note written subsequent
3 to him arriving at the floor after the
4 procedure?
5 A. Clinical note. 16:03:56
6 Q. Clinical note, right?
7 A. But there are separate nurses notes
8 like I have received this patient, this is my
9 assessment, and I think we can probably --
10 Q. Thanks for clarifying that, but I 16:04:05
11 meant clinical note.
12 A. I'm just not sure the distinction
13 between a nurse clinical note and the --
14 because they're both written by nurses.
15 Q. Okay. You are so thorough, Doc. 16:04:14
16 A. No, I'm just trying to answer your
17 questions as directly as possible.
18 Q. I know. All right.
19 A. Because in fairness, there probably
20 are other notations by other healthcare givers. 16:04:24
21 Q. Sure.
22 A. But thank you, that was a
23 compliment.
24 Q. You are looking for what, physician
25 notations? 16:04:56

1 A. Nurses notes. You had asked me a 16:04:57
2 question if he had been reevaluated somewhere
3 between his arrival to the floor and this first
4 note of 4 o'clock, and there, you have beat me
5 to them. 16:05:04
6 Q. I'm showing you what's marked as
7 nursing progress records. And we're going
8 to -- appears to be 1445?
9 A. Yes.
10 Q. Okay. And if you can interpret 16:05:17
11 that, and I don't expect you to, but --
12 A. This is a copy, but it looks like
13 it says 1445 patient returns from PCAT, sheath
14 7 French in left groin site without, without --
15 MR. JONES: Want my help? 16:05:37
16 Q. Do you have the original? It would
17 be better.
18 MR. JONES: Go ahead, I think he
19 figured it out. I think it's an abbreviation
20 for draining. 16:05:45
21 A. -- without draining and without
22 hematoma and sheath transduced, ReoPro at 72,
23 normal saline at 150.
24 Q. Patient 72 or 22?
25 A. Sorry, thank you. 22 cc's per 16:05:55

1 hour, I think is what it specifically says, 16:05:55
2 normal saline at 150 cc's per hour. Patient
3 without complaints of chest pain, shortness of
4 breath, dizziness, nausea, diaphoresis. 1500,
5 patient complains of nausea and small clear 16:06:07
6 emesis. Blood pressure is 178/91.
7 Q. Is that a narrow elevated BP?
8 A. I don't think so. I think it may
9 be.
10 Q. Okay. Appears Reglan was given? 16:06:22
11 A. Yes.
12 Q. And that's at 1500 hours?
13 A. Correct.
14 Q. Which would be 3 o'clock p.m.?
15 A. Correct. 16:06:31
16 Q. All right. Then there's a note,
17 1525?
18 A. Oh, this is an A maybe, arterial
19 blood pressure.
20 Q. Okay. 1525, arterial blood 16:06:40
21 pressure remains elevated?
22 A. Yes.
23 Q. Is that Dr. Moliterno's service
24 or --
25 A. Yes, Dr. Moliterno's service. And 16:06:51

1 up to see. 16:06:54

2 Q. Patient EKG done?

3 A. Yes.

4 Q. Patient remains nauseated?

5 A. Yes. 16:07:00

6 Q. Very diaphoretic?

7 A. (Nodding affirmatively.)

8 Q. At that point in time, are those

9 symptoms consistent with intracerebral bleed?

10 A. Not necessarily, no. 16:07:08

11 Q. May they be?

12 A. Anything is possible, so yes, they

13 may be.

14 Q. Okay. My question is is it

15 possible Mr. Yurick, this gentleman, was 16:07:16

16 already having intracerebral hemorrhage 3

17 o'clock, 3:30 in the afternoon?

18 A. It's speculative, I guess, but

19 possible, sure.

20 Q. Why is it speculative? 16:07:27

21 A. Because he has no complaint, and I

22 have to go back and read that, I guess.

23 Q. I'm sorry. I don't want to take it

24 away from you.

25 A. Because there is no distinguishing 16:07:37

1 features to say that he is having a neurologic
2 dysfunction.

16:07:39

3 Q. Well, his arterial blood pressure's
4 elevated, correct?

5 A. About ten million Americans.

16:07:51

6 Q. The patient's nauseous, correct?

7 A. He is, yes.

8 Q. Diaphoretic?

9 A. Yes.

10 Q. Elevated blood pressure?

16:08:04

11 A. Yes.

12 Q. Are those symptoms, is it, those
13 symptoms consistent with intracerebral
14 hemorrhage? May they be consistent with
15 intracerebral hemorrhage?

16:08:16

16 A. I don't think, I don't think so.
17 They may be, but I don't think so.

18 Q. Would you have intracerebral
19 hemorrhage prior to developing symptoms?

20 A. I don't know. I don't know the
21 percentage of patients developing intracerebral
22 hemorrhage who have or have not heralding
23 symptoms such as these.

16:08:26

24 Q. Would you agree with me, though, by
25 4:15 this gentleman had significant

16:08:38

1 intracerebral hemorrhage?

16:08:41

2 A. I would not say that was
3 conclusive. I would say at whatever time he
4 had neurologic dysfunction, whether or not at
5 that juncture you can say it's from
6 intracerebral hemorrhage, that's another story.

16:08:49

7 Q. I'm sorry, you can or cannot say?

8 A. At 4:15 I cannot say that he has
9 intracerebral hemorrhage by any means.

10 Q. At 4:15 we know he's obtunded,
11 correct?

16:09:00

12 A. He's confused, he's reportedly
13 confused, yes.

14 Q. I'm sorry, at 4:20 he's obtunded?

15 A. Yes.

16:09:10

16 Q. Fair to say he has intercerebral
17 hemorrhage at 4:20?

18 A. The question, if I may repeat your
19 question, was did we know he had an
20 intracerebral hemorrhage at that time, and the
21 answer is no. I mean that's what a neurologist
22 was called for and a head CT was done for. If
23 we'd have known, we may not have needed those
24 things.

16:09:19

25 Q. Should it have been considered?

16:09:29

1 MR. JONES: At what time? 16:09:31

2 MR. FINELLI: 4:20.

3 A. Yes.

4 Q. Should it have been considered at

5 4:15? 16:09:38

6 A. The exact time of which I'm not

7 sure, but certainly when the patient became

8 confused, I think it's very reasonable to

9 consider neurologic dysfunction from ischemic

10 or hemorrhagic or drug induced cerebrovascular 16:09:54

11 ischemia.

12 Q. About 4 p.m. when he's nauseous,

13 has emesis and has elevated blood pressure,

14 should it have considered hemorrhage?

15 A. Not necessarily, no. 16:10:12

16 Q. Why not? This is a gentleman that

17 had --

18 A. Because the probability is so

19 increasingly low, but it's -- I mean should

20 have been considered within odds of a thousand 16:10:19

21 to one? I'm not sure.

22 Q. So you considered it a red herring

23 at that point in time?

24 A. I would consider it to be

25 strikingly unusual for those symptoms to be 16:10:28

1 indicative of someone having intracerebral 16:10:30
2 hemorrhage, yes.

3 Q. Let me just turn to your note
4 1-15-96 at 2010.

5 A. Okay. 16:11:25

6 Q. You notice you write hours after
7 angioplasty Mr. Yurick had nausea and vomiting
8 and altered mentation?

9 A. Yes.

10 Q. And had evidence of intracranial 16:11:45
11 bleeding and had been swiftly and aggressively
12 treated?

13 A. Yes.

14 Q. How was he swiftly and aggressively
15 treated? 16:11:54

16 A. Neurology was promptly called, his
17 ReoPro was discontinued, and a CAT scan was
18 ordered and the neurosurgical, we have an acute
19 neurointerventional team that was called.

20 Q. This was all done subsequent to him 16:12:12
21 being obtunded at 4:20 p.m.?

22 A. Yes.

23 Q. All right. Looking at the hospital
24 expiration summary, it's written by
25 Dr. Pileski, she writes attempts were made to 16:12:41

1 reverse his anticoagulation. My question is 16:12:50
2 what attempts were made to reverse his
3 anticoagulation?

4 A. Obviously I didn't dictate that,
5 but you can see from the record what was done. 16:13:02

6 Q. What was done? Just the platelet
7 transfusion and the discontinued the ReoPro?

8 A. That's correct.

9 Q. Again, that was all done subsequent
10 to him being obtunded at 4:20 p.m.? 16:13:12

11 A. That's correct. He also was, I
12 think, given, at least by my note, fresh frozen
13 plasma.

14 Q. Along with the platelet
15 transfusion? 16:13:27

16 A. That's correct.

17 Q. Again, after the 4:20 p.m. note of
18 him being obtunded?

19 A. That's correct.

20 Q. Did you speak with Mrs. Yurick 16:13:37
21 after the death of Mr. Yurick?

22 A. I don't -- oh, yes, after his
23 death, sure.

24 Q. Tell me about that conversation.

25 A. I don't remember when, but I spoke 16:13:50

1 with her several times, twice specifically in 16:13:51
2 my office at her request, to review some of the
3 events of the case with her initially. I think
4 one of her children was on spring break or in
5 town, I don't remember which, and he and she 16:14:06
6 and perhaps a third person came again to review
7 some of these events and the case in general.

8 Q. Prior to this deposition, did you
9 review the medical records of Mr. Yurick?

10 A. I'm sorry. 16:14:27

11 Q. Prior to preparing -- as
12 preparation of this deposition, did you review
13 the medical records of Mr. Yurick?

14 A. Yes, some.

15 Q. Would you agree that other than the 16:14:37
16 focal lesion in the diagonal branch of the LAD
17 in October and again in January of 96, October
18 of 95 and January of 96, other than that
19 lesion, Mr. Yurick's past medical history was
20 unremarkable? 16:14:58

21 A. I don't remember.

22 Q. Is there any --

23 A. He has atherosclerosis. I know of
24 at least two hospitalizations we have discussed
25 today for an acute coronary syndrome related to 16:15:09

1 atherosclerosis. We have seen hypertension. I 16:15:13
2 can't recollect his other past medical history.

3 Q. All right. Let me dissect that a
4 little bit. You said he has atherosclerosis?

5 A. Yes. 16:15:24

6 Q. It was documented atherosclerosis
7 in the first diagonal branch of the LAD?

8 A. Severe atherosclerosis was
9 diagnosed in the first diagonal branch of his
10 LAD, that's correct. 16:15:34

11 Q. Okay. Where else in the vascular
12 system did he have evidence of atherosclerosis?

13 A. I have to review. Would you like
14 me to?

15 Q. Sure. 16:15:43

16 A. Okay.

17 Q. Did he have any evidence of carotid
18 disease?

19 A. The circumflex is described as
20 having a 30 percent stenosis in the proximal 16:15:59
21 portion. The left anterior itself is described
22 as having a 30 percent stenosis in its
23 midportion.

24 Q. Would you consider those lesions as
25 mild? 16:16:11

1 A. I would consider them on the 16:16:11
2 mild/moderate range, yes. I would describe
3 them as being overt evidence of
4 atherosclerosis.

5 Q. Certainly no intervention 16:16:19
6 necessary?

7 A. Correct. No revascularization
8 intervention. Medical intervention, blood
9 pressure and all those medical interventions.

10 Q. Medical therapy, but no invasive 16:16:33
11 intervention?

12 A. Correct.

13 Q. Other than what you have just told
14 me about his coronary arteries, any evidence of
15 atherosclerosis elsewhere, i.e. the carotids, 16:16:41
16 lower extremities?

17 A. I don't know of them being
18 evaluated. My recollection, I don't know of
19 them being evaluated.

20 Q. But none of the records reflect, 16:16:49
21 records that you have there, reflect any
22 evidence of --

23 A. I don't know.

24 Q. Well, you have them in front of
25 you. Can you tell me if they do? 16:17:00

1 A. It would take a while to read
2 through them all because he wasn't under my
3 primary care, I don't know if he ever had, for
4 example, any other evaluations for
5 atherosclerosis.

16:17:07

16:17:09

6 Q. If he did have significant
7 atherosclerosis in those areas, would it be
8 mentioned in the admission note of 1-13-96?

9 A. Not necessarily, and it may not be
10 determinable by such methods as carotid
11 ultrasound, small cerebrocoronary vasculature
12 is often difficult to discern even with the
13 best of medical diagnostic capabilities.

16:17:21

14 Q. And you spoke with Mr. Yurick prior
15 to doing the procedure?

16:17:34

16 A. Yes, I did.

17 Q. You would have evaluated him prior
18 to doing the procedure?

19 A. In some respects, yes, I did.

20 Q. Did he voice any complaints that
21 would relate to carotid disease to you?

16:17:45

22 A. Not to my recollection.

23 Q. Did he voice any claudication
24 complaints?

25 A. Not to my recollection, but I don't

16:17:55

1 know if I necessarily asked him about
2 claudication. I don't remember.

16:17:56

3 Q. You did the AA cardiac
4 catheterization through the groin?

5 A. That's correct.

16:18:03

6 Q. Would you not want to be concerned
7 about severe atherosclerosis of the
8 aortoiliofemoral system --

9 A. Yes.

10 Q. -- prior to doing a catheterization
11 through the femoral artery?

16:18:10

12 A. Yes, sir.

13 Q. Were you concerned about any
14 atherosclerosis in his aortoiliac system?

15 A. Was I concerned? Not necessarily
16 concerned, but do I think there are some
17 present? Most likely. Was it severe? Not to
18 my knowledge.

16:18:22

19 Q. No more severe than any man his
20 age?

16:18:35

21 A. I disagree. Likely it is more
22 severe than any man his age based on his
23 coronary atherosclerosis, you know that those
24 patients in general have more systemic
25 atherosclerotic disease than a man of their

16:18:45

1 age.

16:18:4

2 Q. Do you know if Mr. Yurick was
3 diabetic?

4 A. You probably know. I don't
5 remember that.

16:19:02

6 Q. You mentioned that he had
7 hypertension and I think that was relative to
8 the nursing note at the time he had arterial
9 blood pressure elevation subsequent to his
10 catheterization. Do you know if he had a
11 history of essential hypertension?

16:19:13

12 A. I don't.

13 Q. Do you know if he was on any
14 antihypertensive medication prior to the
15 admission of 1-13-96?

16:19:23

16 A. I don't.

17 Q. Has the Cleveland Clinic ever been
18 sued, Doctor, where you have been alleged to
19 have provided negligent care, other than this,
20 this case?

16:19:44

21 A. Not to my knowledge.

22 Q. You would agree that Mr. Yurick
23 developed severe intracerebral hemorrhage
24 following the angioplasty?

25 A. I don't know the degree, what

16:20:25

1 severe means, but he certainly had an 16:20:26
2 intracerebral hemorrhage following his
3 angioplasty, yes.

4 Q. And Mr. Yurick had an autopsy?

5 A. To my knowledge he had a limited 16:20:37
6 evaluation of his brain, but not, for example,
7 the aortoiliac system as discussed earlier.

8 Q. And would you agree that the cause
9 of death of Mr. Yurick was intracerebral
10 hemorrhage? 16:20:48

11 A. Yes.

12 Q. Would you agree that his --

13 A. Or complications resulting
14 therefrom.

15 Q. Secondary to intercerebral 16:20:53
16 hemorrhage?

17 A. Yes.

18 Q. Would you agree that his
19 intercerebral hemorrhage was due to Mr. Yurick
20 being overanticoagulated? 16:20:59

21 A. No.

22 Q. Why not?

23 A. Because I don't think he was
24 overanticoagulated.

25 Q. Why do you think he developed a 16:21:08

1 cerebral hemorrhage following his angioplasty?

16:21:10

2 A. I don't know.

3 MR. FINELLI: No further questions.

4 MR. JONES: He'll read it, if he
5 orders it.

16:21:22

6 (Deposition concluded at 4:20 p.m.)

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1 CERTIFICATE

2 The State of Ohio,)

3 SS:

4 County of Cuyahoga.)

5
6 I, Denise M. Munguia, a Notary
7 Public within and for the State of Ohio, duly
8 commissioned and qualified, do hereby certify
9 that the within named witness, DAVID J.
10 MOLITERNO, M.D., was by me first duly sworn to
11 testify the truth, the whole truth and nothing
12 but the truth in the cause aforesaid; that the
13 testimony then given by the above-referenced
14 witness was by me reduced to stenotypy in the
15 presence of said witness; afterwards
16 transcribed, and that the foregoing is a true
17 and correct transcription of the testimony so
18 given by the above-referenced witness.

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

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

5 IN WITNESS WHEREOF, I have hereunto
6 set my hand and affixed my seal of office at
7 Cleveland, Ohio, on this 12th day of
8 May, 1999.

9
10
11
12
13 

14 Denise M. Munquia, Notary Public
15 within and for the State of Ohio
16

17 My commission expires May 23, 2000.
18
19
20
21
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23
24
25

I N D E X

EXAMINATION OF DAVID J. MOLITERNO, M.D.

BY MR. FINELLI..... 3:6

Exhibit 1 was marked..... 13:20

SIGNATURE OF WITNESS

The deposition of DAVID MOLITERNO,
M.D., taken in the matter, on the date, and at
the time and place set out on the title page
hereof.

It was requested that the
deposition be taken by the reporter and that
same be reduced to typewritten form.

It was agreed by and between
counsel and the parties that the Deponent will
read and sign the transcript of said
deposition.

AFFIDAVIT

The State of Ohio,)

) SS:

County of Cuyahoga)

Before me, a Notary Public in and for
said County and State, personally appeared
DAVID MOLITERNO, M.D., who acknowledged that
he/she did read his/her transcript in the
above-captioned matter, listed any necessary
corrections on the accompanying errata sheet,
and did sign the foregoing sworn statement and
that the same is his/her free act and deed.

In the TESTIMONY WHEREOF, I have hereunto
affixed my name and official seal at this _____
day of _____ A.D 1999.

Notary Public

My Commission Expires:

DEPOSITION ERRATA SHEET

RE: Patricia A. Yurick, Executrix of
the Estate of Martin A. Yurick vs.
Cleveland Clinic Foundation, et al.

RRS File No.: 1239

Deponent: DAVID MOLITERNO, M.D.

Deposition Date: May 5, 1999

To the Reporter:

I have read the entire transcript of my
Deposition taken in the captioned matter or the
same has been read to me. I request that the
following changes be entered upon the record
for the reasons indicated. I have signed my
name to the Errata Sheet and the appropriate
Certificate and authorize you to attach both to
the original transcript.

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Children: Nathaniel and Benjamin

Education

Undergraduate

College of Arts and Sciences
University of Michigan, Ann Arbor, Michigan
B.S. Honors, Biology, 1978-1982

Medical School

Medical College of Virginia
Virginia Commonwealth University, Richmond, Virginia
Doctor of Medicine, 1983-1987

Post Doctoral Training

Internship

Vanderbilt University Hospitals
Vanderbilt University Medical Center, Nashville, Tennessee
Intern in Internal Medicine, 1987-1988

Residency

Vanderbilt University Hospitals &
Nashville Veterans Affairs Medical Center
Vanderbilt University Medical Center, Nashville, Tennessee
Junior and Senior Resident in Internal Medicine, 1988-1990

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Post Doctoral Training

continued

Fellowships

Parkland Memorial Hospital &
Dallas Veterans Affairs Medical Center
University of Texas, Southwestern Medical Center, Dallas, Texas
Fellow in Cardiovascular Medicine, 1990-1993

Department of Cardiology
Section of Interventional Cardiology
The Cleveland Clinic Foundation, Cleveland, Ohio
Fellow in Interventional Cardiology, 1993-1994

Professional Activities

Faculty Appointments

Staff Physician
Section of Interventional Cardiology
Department of Cardiology
The Cleveland Clinic Foundation, Cleveland, Ohio, 1994-present

Medical Director, Angiographic Core Laboratory
Section of Cardiac Catheterization
Department of Cardiology
The Cleveland Clinic Foundation, Cleveland, Ohio, 1994-present

Assistant Professor of Medicine
Department of Cardiology
Cleveland Clinic Health Science Center
The Ohio State University, 1994-present

Staff Physician
Department of Cardiology
MetroHealth Medical Center
Cleveland, Ohio, 1995-present

Accomplishments

Honors

Psi Chi - National Honor Society, 1982
Merck Scholastic Achievement Award, 1985
Bristol Cardiology Fellow Award, 1991
Syntex Cardiology Fellow Award, 1992

Listed in "Best Physicians in America", 1998

Certificates & Licensure

Advanced Cardiac Life Support, 1993
Advanced Trauma Life Support, 1992
Board Certification in Internal Medicine (ABIM), 1991
Board Certification in Cardiovascular Medicine (ABIM), 1993
State of Tennessee, medical license, 1988 (inactive)
State of Texas, medical license, 1990 (inactive)
State of Ohio, medical license, 1993-present

Academic Activities

Memberships

American College of Cardiology, Fellow (FACC)
American College of Physicians, Fellow (FACP)
American Heart Association
 Arteriosclerosis and Thrombosis Council
 Clinical Cardiology Council
American Medical Association
European Society of Cardiology, Fellow (FESC)

Frequent Journal Reviewer

American Heart Journal
American Journal of Cardiology
Chest
Circulation
Coronary Artery Disease
Journal of the American College of Cardiology
Journal of Invasive Cardiology
Lancet
Thrombosis and Haemostasis

Editorial Boards

Section Editor, Clinical Trials,
Journal of Thrombosis and Thrombolysis

Investigatorships & Committees

Recent Past:

1. Clinical Events Committee: Global Use of Strategies to Open Occluded Arteries in Acute Coronary Syndromes (GUSTO II); CIBA-Geigy, Boehringer-Mannheim, Advanced Cardiovascular Systems.
2. Clinical Events Committee: A Randomized, Double-Blind, Comparative Safety and Efficacy Evaluation of Integrelin in Patients Receiving Thrombolytic Therapy for Acute Myocardial Infarction (IMPACT-AMI); COR Therapeutics.
3. Angiographic Core Laboratory Director: Evaluation of PTCA to Improve Long-term Outcomes by c7E3 Glycoprotein Receptor Blockade (EPILOG); Centocor, Eli Lilly.
4. Study Co-Principal Investigator: Prevention of Reocclusion and Inhibition of Thrombus and Myocardial Events (PRIME) Trial; A Randomized Trial of Efgatran Sulfate Versus Heparin in Acute Myocardial Infarction; Eli Lilly.
5. Angiographic Core Laboratory Director: Reteplase vs Alteplase Investigation During Myocardial Infarction Trial (RAPID 2); Randomized, Double-blind Study Comparing the Efficacy of Double Bolus Reteplase to Accelerated tPA in Patients with Acute Myocardial Infarction; Boehringer Mannheim.
6. Study Co-Principal Investigator: Platelet Aggregation Receptor Antagonist Dose Investigation for Reperfusion Gain in Myocardial Infarction (PARADIGM) Study: A Randomized Double-Blind Phase II Trial Evaluating the Use of a GP IIb/IIIa Inhibitor, Lamifiban Vs Placebo for Patients with Acute Myocardial Infarction; Hoffmann-LaRoche.
7. Study Principal Investigator: Platelet IIb/IIIa Antagonism for the Reduction of Acute Coronary Syndrome Events in a Global Organization Network (PARAGON); Randomized Double-Blind Trial to Evaluate the Use of GP IIb/IIIa Inhibitor, Lamifiban Vs Placebo for Patients with Acute Coronary Syndromes; Hoffmann-LaRoche.
8. Chairman, Steering Committee: Global Unstable Angina Registry and Treatment Evaluation (GUARANTEE) Study: A Survey of Treatment Practice Patterns for Patients with Unstable Angina; Eli Lilly.
9. Angiographic Core Laboratory Director: Liposomal Intervention Followed by Thrombolysis (LIFT) Trial: A Phase II, Placebo-Controlled, Multicenter Study of TLC C-53 as an Adjunct to Thrombolytic Therapy in Patients with Acute Myocardial Infarction; The Liposome Company.

Investigatorships & Committees

continued

10. Study Co-Investigator: Gene Quest - Genetic Analysis of Complex Human Traits: Application to Premature Atherosclerotic Heart Disease; Millennium Pharmaceuticals.
11. Site Principal Investigator: Determinants of the Time of Myocardial Infarction Onset. Part II: Modifiers of Myocardial Infarction Onset; National Heart, Lung and Blood Institute of the National Institute of Health.
12. International Steering Committee: Global Use of Strategies to Open Occluded Arteries in Acute Coronary Syndromes (GUSTO III): A Randomized Trial of Reteplase (r-PA) Versus Accelerated Alteplase (t-PA) for the Treatment of Acute Myocardial Infarction. Boehringer-Mannheim.

Current:

13. Angiographic Core Laboratory Director: ReoPro in Acute Myocardial Infarction and Primary PTCA Organization and Randomized Trial (RAPPORT); Eli Lilly and Centocor.
14. Angiographic Core Laboratory Director: A Phase II Randomized, Open-Label Angiographic Trial Evaluating The Benefit of ReoPro™ Bolus Plus 12-Hour Infusion With And Without Thrombolytic Therapy For Acute Myocardial Infarction (GUSTO-IV Pilot); Centocor and Eli Lilly.
15. Study Co-Principal Investigator: SYMPHONY: Sibrifiban Versus Aspirin to Yield Maximum Protection From Ischemic Heart Events Post-Acute Coronary Syndromes; Genentech and Hoffmann-LaRoche.
16. Study Co-Principal Investigator: Platelet IIb/IIIa Antagonism for the Reduction of Acute Coronary Syndrome Events in a Global Organization Network (PARAGON-B); Phase III Randomized Double-Blind Trial to Evaluate the Use of Lamifiban Vs Placebo for Patients with Acute Coronary Syndromes; Hoffmann-LaRoche.
17. Angiographic Core Laboratory Director: Evaluation of IIb/IIIa Platelet Inhibition for Stenting (EPISTENT) Trial: A phase IV clinical trial of Abciximab, intracoronary stent placement, or both in elective percutaneous coronary revascularization procedures; Centocor, Eli Lilly.
18. Study Co-Principal Investigator: The 2nd SYMPHONY: Sibrifiban (Xubix™) Versus Aspirin to Yield Maximum Protection From Ischemic Heart Events Post-Acute Coronary Syndromes: A randomized trial of chronic (1-year) administration of oral IIb/IIIa inhibition versus aspirin; Genentech and Hoffmann-LaRoche.

Investigatorships & Committees

continued

19. Angiographic Core Laboratory Director: Local Delivery of Heparin in Stenting for Sub-Optimal result or Threatened Closure Post-PTCA using the LocalMed Infusaleeve: a Multicenter Randomized Pilot Study (LIHPS); LocalMed.
20. Scientific Advisory Board Member, International Academy of Cardiology, Inc. and the 1st International Congress on Heart Disease, May, 1999.
21. Angiographic Core Laboratory Director: Feasibility Study of the EndoTex Coiled Sheet Stent in the Treatment of Carotid Arterial Stenosis (ESCS-I); EndoTex Interventional Systems.
22. Scientific Advisory Board Member, International Academy of Cardiology, Inc. and the 2nd International Congress on Heart Disease, June, 2000.
23. Site Principal Investigator: The Safety of Enoxaparin Therapy in Patients Undergoing Percutaneous Coronary Intervention and Receiving Concomitant Abciximab Therapy (NICE-4). Rhône-Poulenc Rorer Pharmaceuticals.
24. Angiographic Core Laboratory Director: A Prospective, Randomized, Double Blind, Multicenter Study Comparing the Effects of Atorvastatin versus Pravastatin on the Progression and Quantification of Coronary Atherosclerotic Lesions as Measured by Intravascular Ultrasound (REVERSAL) Study. Parke-Davis Pharmaceutical Research and Pfizer Central Research.
25. Angiographic Core Laboratory Director: Norvasc for Regression of Manifest Atherosclerotic Lesion by Intravascular Sonographic Evaluation (NORMALISE) Study. Pfizer US Pharmaceuticals.
26. Site Principal Investigator: Heparins and Reperfusion Trial (HART-II): A comparison of unfractionated heparin and enoxaparin among patients receiving tissue plasminogen for acute myocardial infarction. Rhône-Poulenc Rorer Pharmaceuticals.
27. Scientific Advisory Board Member: 3rd International Congress on Coronary Artery Disease; Salzburg, Austria, October, 2000.
28. Steering Committee: A prospective, multicenter, observational study evaluating platelet function with Accumetrics Ultegra-Rapid Platelet Function Assay (RPFA) in patients undergoing coronary interventions using platelet glycoprotein IIb/IIIa inhibitors. Accumetrics, Inc.

**University, Scientific Society,
& International Lectures**

1. September, 1995
The Austrian Society of Cardiology and The Working Group on
Coronary Circulation of the European Society of Cardiology;
Vienna, Austria
Definition and Specification of Coronary Lesions: Angiography and Beyond
2. September, 1995
Ohio State University; Columbus, OH
Use of IIb/IIIa Platelet-Receptor Antagonists in Interventional Cardiology
3. December, 1995
The George Washington University Medical School; Washington, D.C.
Platelet Integrins and Receptor Antagonists in Cardiovascular Medicine
4. January, 1996
23rd Annual Scientific Meeting of Egyptian Society of Cardiology;
Luxor, Egypt
Contemporary Percutaneous Revascularization: State of the Art
5. May, 1996
Institute di Ricovero e Cura a Carattere Scientifico;
Como, Italy
Anti thrombotic Therapy in Acute Coronary Syndromes: IIb/IIIa in AMI
6. October, 1996
Scientific Experts Panel Advisory Meeting; Glaxo Pharmaceuticals;
London, England
*Biologic Role and Potential Indications for Chronic Platelet IIb/IIIa Antagonism
in Cardiovascular Medicine*
7. December, 1996
The Cardiac Center of Creighton University; Omaha, Nebraska
Anticoagulation: The role of IIb/IIIa Platelet Inhibitors
8. January, 1997
Georgia Heart Institute University Hospital; Augusta, Georgia
Contemporary Diagnosis & Therapy of Acute Myocardial Infarction
9. April, 1997
61st Annual Scientific Meeting of Japanese Circulation Society;
Tokyo, Japan
Megastudies in Ischemic Heart Disease: When are Meta-Analyses Adequate?
10. June, 1997
XIXth Annual Congress of the International Society on Thrombosis
and Haemostasis; Florence, Italy
*Conjunctive Use of Platelet Glycoprotein IIb/IIIa Antagonists and Thrombolytic
Therapy for Acute Myocardial Infarction*

**University, Scientific Society,
& International Lectures**

continued

11. June, 1997
The University of Texas & The Texas Heart Institute; Houston, Texas
Emerging Strategies in the Treatment of Acute Coronary Syndromes
 12. August, 1997
XIXth Congress of the European Society of Cardiology,
Stockholm, Sweden
Non-Cardiac Uses of ReoPro: Cerebrovascular Interventions
 13. October, 1997
The University of South Dakota, Sioux Falls; South Dakota
Strategies to Improve Myocardial Reperfusion in Acute Infarction
 14. December, 1997
The Singapore Society of Cardiology;
Singapore, Singapore
Antiplatelet and Antithrombin Therapies: The Next Generation
 15. May, 1998
The University of Texas, Southwestern Medical Center, Dallas, Texas
Contemporary Strategies to Maximize Perfusion and Reperfusion in Acute Coronary Syndromes
 16. May, 1998
Henry Ford Hospital, Detroit, Michigan
Current Antiplatelet and Antithrombin Therapies in Unstable Angina and Myocardial Infarction
 17. May, 1998
The Philippine Heart Association 29th Annual Scientific Meeting,
Manila, Philippines
The 2nd Annual Rodolfo Soto Visiting Professor Lecture: Confronting the Challenges of Acute Ischemic Syndromes
 18. June, 1998
The 9th Annual Meeting of the Society for Vascular Medicine And
Biology, San Diego, California
Antiplatelet Therapies in Cardiology and Vascular Medicine
 19. September, 1998
The 2nd International Congress of the Polish Cardiac Society;
Katowice, Poland
Clinical Application of IIb/IIIa Inhibitors in Acute Coronary Syndromes
 20. October, 1998
Scientific Experts Advisory Panel Meeting, Yamanouchi
Pharmaceuticals; Amsterdam, The Netherlands
Broadening the Application of IIb/IIIa Inhibitors in Vascular Medicine
-

**University, Scientific Society,
& International Lectures**

continued

21. October, 1998
Annual Scientific Session of the American College of Emergency Physicians; San Diego, California
From Clinical Trials to Clinical Practice: What Have We Learned from the EPIC, EPILOG, CAPTURE, 4P Trials?
22. January, 1999
Bowman Gray School of Medicine
Wake Forest University, Winston-Salem, North Carolina
Contemporary Antiplatelet and Antithrombin Therapies in Acute Coronary Syndromes
23. January, 1999
University of North Carolina at Chapel Hill, Chapel Hill, North Carolina
New Options in Antiplatelet Therapies for Acute Coronary Syndromes
24. March, 1999
The University of Cincinnati School of Medicine, Cincinnati, Ohio
Tailoring Therapies of Acute Myocardial Infarction for Individual Patients

Publications

Abstracts

1. Brogan WC, Lange RA, Kim AS, **Moliterno DJ**, Hillis LD. Alleviation of cocaine-induced coronary vasoconstriction by nitroglycerin. *Journal of the American College of Cardiology* 1991; 17:174A.
 2. **Moliterno DJ**, Leffert CC, Lange RA, Willard JE, Boerwinkle EA, Hillis LD, Hobbs HH. Plasma lipoprotein[a] in black subjects with and without angiographic evidence of coronary atherosclerosis. *Circulation* 1992; 86 (Suppl I):337.
 3. **Moliterno DJ**, Lange RA, Meidell RS, Willard JE, Leffert CC, Boerwinkle EA, Gerard RD, Hobbs HH, Hillis LD. Relation of lipoprotein[a] to infarct artery patency in survivors of myocardial infarction. *Circulation* 1992; 86 (Suppl I):803.
 4. **Moliterno DJ**, Willard JE, Lange RA, Negus BH, Boehrer JD, Glamann DB, Landau C, Rossen JD, Winniford MD, Hillis LD. Potentiation of cocaine-induced coronary vasoconstriction by cigarette smoking. *Circulation* 1993; 88 (Suppl I):I-254.
 5. **Moliterno DJ**, Sapp SK, Topol EJ. The paradoxical effect of thrombolytic therapy for unstable angina: meta-analysis. *Journal of the American College of Cardiology* 1994; 23:288A.
 6. **Moliterno DJ**, Califf RM, Anderson K, Sigmon KN, Aguirre F, Weisman HF, Topol EJ and EPIC Study Investigators. Activated clotting time is increased during coronary interventions with platelet IIb/IIIa antagonism: results from the EPIC trial. *Journal of the American College of Cardiology* 1994; 23:106A.
 7. De Franco AC, Nissen SE, Tuzcu EM, Lefkovits J, **Moliterno DJ**, Guyer S, Ellis SG. Ultrasound plaque morphology predicts major dissections following stand-alone and adjunctive balloon angioplasty. *Circulation* 1994;90 (Suppl I):I-59.
 8. Goodhart DM, Nissen SE, De Franco AC, Guyer S, **Moliterno DJ**, Tuzcu EM. Diagnosis of angiographically elusive left main and ostial left anterior descending lesions by intravascular ultrasound. *Circulation* 1994;90 (Suppl I):I-450.
 9. Berkalp B, Nissen SE, De Franco AC, **Moliterno DJ**, Franco I, Raymond RE, Sutton J, Lincoff AM, Guyer S, Tuzcu EM. Intravascular ultrasound demonstrates marked differences in surface and lumen shape following interventional devices. *Circulation* 1994;90 (Suppl I):I-58.
 10. **Moliterno DJ**, Stebbins A, Maynard C. The influence of race on efficacy and complications of thrombolytic therapy: results from the GUSTO trial. *Circulation* 1994;90 (Suppl I):I-109.
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Publications

Continued

Abstracts

11. De Franco AC, Tuzcu EM, **Moliterno DJ**, Guyer S, Elliott JM, Nissen SE. Do new interventional devices "facilitate" balloon angioplasty? Ultrasound evidence of no reduction in vessel recoil. *Circulation* 1994;90 (Suppl I):I-58.
12. Tuzcu EM, Berkalp B, **Moliterno DJ**, Goormastic M, De Franco AC, Nissen SE. Can angiography reliably detect and quantify coronary calcification? A comparative intravascular ultrasound study. *Circulation* 1994;90 (Suppl I):I-277.
13. De Franco AC, Tuzcu EM, **Moliterno DJ**, Elliott JM, Berkalp B, Franco I, Raymond RE, Whitlow PL, Guyer S, Nissen SE. Overestimation of lumen size after coronary interventions: implications for randomized trials of new devices. *Circulation* 1994;90 (Suppl I):I-550.
14. **Moliterno DJ**, Califf RM, Anderson K, Aguirre F, Weisman HF, Topol EJ and EPIC Study Investigators. Special considerations for diabetics receiving platelet IIb/IIIa antagonists during coronary interventions: Results from the EPIC trial. *Journal of the American College of Cardiology* 1995;25:155A.
15. Mayer EL, Robinson K, Jacobsen DW, Tuzcu EM, De Franco AC, **Moliterno DJ**, Guyer S, Nissen SE. Low plasma homocysteine levels predict reduced atheroma burden in patients undergoing coronary interventions: evidence from coronary intravascular ultrasound. *Journal of the American College of Cardiology* 1995;25:81A.
16. **Moliterno DJ**, De Franco AD, Tuzcu EM, Ellis SG, Eccleston DS, Raymond RE, Whitlow PL, Nissen SE. Intravascular ultrasound evidence of significant oversizing of angioplasty balloons in female patients. *Journal of the American College of Cardiology* 1995;25:94A.
17. Tuzcu EM, De Franco AC, Mayer E, **Moliterno DJ**, Hobbs RE, Bott-Silverman C, Stewart RW, McCarthy PM, Nissen SE. Older donor age predicts increased risk for coronary vasculopathy in the year following transplantation: serial examination by intravascular ultrasound. *Journal of the American College of Cardiology* 1995;25:333A.
18. De Franco AD, Tuzcu EM, **Moliterno DJ**, Raymond RE, Franco I, Guyer S, Ellis SG, Whitlow PL, Nissen SE. "Directional" coronary atherectomy removes atheroma more effectively from concentric than eccentric lesions: intravascular ultrasound predictors of lesion success. *Journal of the American College of Cardiology* 1995;25:137A.

Publications
continued

Abstracts

19. **Moliterno DJ**, Granger C, Califf RM, Elliott JM, Stebbins A, Topol EJ for the GUSTO Investigators. Improved prognosis for heavy weight patients receiving thrombolysis in acute myocardial infarction - bigger is better: results from GUSTO. *Journal of the American College of Cardiology* 1995;25:232A.
20. Migrino RQ, Ross AM, Miller DP, Goel JM, and **Moliterno DJ** for the GUSTO Investigators. Lack of circadian variation in thrombolytic efficacy: results from the GUSTO angiographic substudy. *Circulation* 1995;92:I-777.
21. Lincoff AM, Tchong JE, Ellis SG, **Moliterno DJ**, Kitt MM, Debowey D, Topol EJ for the IMPACT II Investigators. Randomized trial of platelet glycoprotein IIb/IIIa inhibition with Integrelin for prevention of restenosis following coronary intervention: the IMPACT II angiographic substudy. *Circulation* 1995;92:I-607.
22. **Moliterno DJ**, Sgarbossa EB, Armstrong PW, Granger CB, Van de Werf F, Califf RM, Topol EJ for the GUSTO II Investigators. A major dichotomy in unstable angina outcome: ST depression vs. T-wave inversion--GUSTO II results. *Journal of the American College of Cardiology*, 1996;27:182A.
23. Steinhubl SR, **Moliterno DJ**, Teirstein PS, Guarneri EM, Aguirre FV, Ferguson JJ, Perin EC, Strickman NE, Keriakes D, Tchong JE, Ellis SG, Topol EJ. Stenting for acute myocardial infarction: the early United States multicenter experience. *Journal of the American College of Cardiology*, 1996;27:279A.
24. De Franco AC, Tuzcu EM, Ziada KM, Magyar WA, Shah N, **Moliterno DJ**, Whitlow PW, Franco I, Ellis SG, Nissen SE. Intravascular ultrasound evidence for balloon oversizing in diabetics: a factor in higher complication rates? *Journal of the American College of Cardiology*, 1996;27:180A.
25. **Moliterno DJ**, Aguirre FV, Cannon CP, Every NP, Granger CB, Sapp SK, Booth JE, Ferguson JJ for the GUARANTEE Investigators. The Global unstable angina registry and treatment evaluation (GUARANTEE) study. *Circulation* 1996;94:I-195.
26. **Moliterno DJ**, Harrington RA, Krucoff MW, Armstrong PW, Van de Werf F, Kristinsson A, Hui W, Paraschos A, Bhapkar M, Rames A, Topol EJ for the PARADIGM Investigators. More complete and stable reperfusion with platelet IIb/IIIa antagonism plus thrombolysis for AMI: The PARADIGM trial. *Circulation* 1996;94:I-553.

Publications

continued

Abstracts

27. **Moliterno DJ** for the PARAGON Investigators. A randomized trial of potent platelet IIb/IIIa antagonism, heparin, or both in patients with unstable angina: THE PARAGON study. *Circulation* 1996;94:I-553.
28. Migrino RQ, Ross AM, Betriu A, Wilcox RG, Miller DP, **Moliterno DJ** for the GUSTO Investigators. Preinfarction angina is not associated with improved outcome after thrombolytic therapy for myocardial infarction: results from GUSTO-I. *Circulation* 1996;94:I-611.
29. Steinhubl SR, **Moliterno DJ**, Ellis SG. Creatine kinase elevations following intracoronary stenting: impact of current technique. *Circulation* 1996;94:I-332.
30. Asher CR, Stebbins AL, Maynard CL, Ross AM, **Moliterno DJ** for the GUSTO Investigators. Long-term survival differences between African American and Caucasians following myocardial infarction: one-year follow-up data from the GUSTO-I trial. *Circulation* 1996;94:I-197.
31. Emanuelsson H, Beatt K, Ardissino D, **Moliterno DJ**, for the GUSTO Investigators. Effect of desirudin treatment on diabetic patients with acute coronary syndromes. *Circulation* 1996;94:I-611.
32. Harrington RA, Newby LK, **Moliterno DJ**, Bhapkar M, Armstrong PW, Simes RJ, White HD, Van de Werf F, Rames A, Topol EJ, Califf RM for the PARAGON Investigators. Combining IIb/IIIa Inhibition and Heparin for Acute Coronary Syndromes: Evidence of a Gradient for Bleeding Hazard from the PARAGON Randomized Factorially Designed Trial. *Journal of the American College of Cardiology* 1997;29:410A.
33. Cannon CP, Ferguson JJ, Every N, Anderson HV, Aguirre FV, Granger CB, French WJ, Sapp S, Booth JE, **Moliterno DJ** for the GUARANTEE Investigators. "Hot" unstable angina - Is it worse than subacute unstable angina? Results from the GUARANTEE registry. *Journal of the American College of Cardiology*, 1997;29:489A.
34. Krucoff MW, Harrington RA, **Moliterno DJ**, Green CL, Trollinger KM, Morgan CD, Burks J, Nygaard T, Pope JE, Topol EJ, Califf, RM for the PARADIGM Investigators. The paradigm for anti-platelet effect on continuous 12-lead ST-segment recovery in Acute MI. *Journal of the American College of Cardiology* 1997;29:185A.
35. **Moliterno DJ**, Asher CA, Califf RM, Clark KA, Guerchi AD, Topol EJ for the GUSTO-IIb Investigators. Less myocardial but more cerebral ischemia in African Americans than Caucasians with acute coronary syndromes: results from GUSTO-II. *Journal of the American College of Cardiology* 1997;29:131A.

Publications

continued

Abstracts

36. Cannon CP, **Moliterno DJ**, Every N, Anderson HV, Aguirre FV, Granger CB, Lambrew CT, Rabbani LE, Arnold A, Scirica BM, Sapp S, Booth JE, Ferguson JJ for the GUARANTEE Investigators. Implementation of the AHCPR guidelines for unstable angina in 1996: Unfortunate differences between men & women - results from the multicenter GUARANTEE registry. *Journal of the American College of Cardiology* 1997;29:217A.
37. Every NR, Cannon C, Granger C, **Moliterno DJ**, Aguirre F, French W, Talley JD, Booth J, Ferguson J for the GUARANTEE Investigators. The influence of insurance type on the use of procedures, medications and hospital outcome in patients with unstable angina. *Journal of the American College of Cardiology* 1997;29:310A.
38. Harrington RA, **Moliterno DJ**, Van de Werf F, Keech A, Kleiman N, Bhapkar M, Rames A, Peek M, Topol EJ, Califf RM, Armstrong PW for the PARAGON Investigators. Delaying and preventing ischemic events in patients with acute coronary syndromes using the platelet glycoprotein IIb/IIIa inhibitor Lamifiban. *Journal of the American College of Cardiology* 1997;29:409A.
39. Alexander JH, Newby LK, **Moliterno DJ**, Bhapkar M, Van de Werf HD, White, Harrington RA, Topol EJ, Califf RM for the PARAGON Investigators. Relationship of outcomes to treatment with Lamifiban in patients undergoing PTCA: Analysis of PARAGON A. *Journal of the American College of Cardiology* 1997; 29:409A.
40. **Moliterno DJ**. Megastudies in ischemic heart disease: When are Meta-analyses adequate? *Japanese Circulation Journal* 1997, 61: I-44.
41. Brener SJ, Barr LA, Burchenal J, Katz S, George BS, Jones AA, **Moliterno DJ**, Topol EJ. A randomized, placebo-controlled trial of abciximab with primary angioplasty for acute MI. The RAPPORT trial. *Circulation* 1997;96:I-473.
42. Harrington RA, **Moliterno DJ**, Newby K, Armstrong PW, van de Werf F, Simes RJ, Rames A, Bhapkar M, Califf RM, Keech A, Topol EJ. Amplification of clinical benefit at six months with the glycoprotein IIb/IIIa inhibitor lamifiban in patients with non ST segment elevation acute coronary syndrome. *Circulation* 1997;96:I-473.
43. **Moliterno DJ**, Harrington RA, Newby K, Bhapkar M, Emanuelsson H, Armstrong PW, Topol EJ. Pronounced reduction in long-term ischemic events with platelet IIb/IIIa antagonism among diabetics with unstable angina: PARAGON 6-month results. *Circulation* 1997;96:I-474.
44. Krucoff MW, Green CL, Trollinger KM, Maas A, **Moliterno DJ**, Harrington RA, O'Connor CM, Pope JE. Enhanced anti-platelet therapy is more important than choice of thrombolytic agent in treatment of myocardial infarction. *Circulation* 1997;96:I-474.

Publications

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