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IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

KEVIN KISS, a minor by
and Through his next friend
and mother, Anne Kiss,
et al,

vs.

Case No.

ANDREAS MARCOTTY, M.D.

402393

- - - - -

Deposition of SAMUEL NEFF, M.D.,
taken pursuant to notice, held at his
offices, 17 White Horse Pike, Suite 3,
Haddon Heights, New Jersey, on Monday,
November 19, 2001, commencing at or
about 9:00 p.m., before Tanya M. Croce,
Court Stenographer Notary Public and
Commissioner of the Commonwealth of
Pennsylvania.

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DEPOSITION OF SAMUEL NEFF, M.D.

<p>Page 2</p> <p>1 APPEARANCES: 2 . 3 On behalf of the Plaintiffs, 4 Becker & Mishkind Co., L.P.A., by 5 JEANNE M. TOSTI, ESQ. 6 Suite 660 Skylight Office Tower 7 1660 West Second Street 8 Cleveland, Ohio 44113 9 . 10 On behalf of Defendant, 11 Cleveland Clinic, 12 Roetzl & Andress, by 13 ANNA CARUM, ESQ. 14 1375 East Ninth Street 15 One Cleveland Center, Tenth floor 16 Cleveland, Ohio 44114 17 . 18 . 19 . 20 . 21 . 22 . 23 . 24 . 25 .</p>	<p>Page 4</p> <p>1 April 23rd of this year. You believe 2 there may be some additional -- 3 A. Publications and I was 4 awarded part of a grant in October. 5 Q. And what would that be, what 6 subject? 7 A. Brain deformation. 8 Q. And just tell me briefly 9 about that, what would that study 10 entail? 11 A. We're working together with 12 a group at John's Hopkins, the principle 13 investigator is Christos Devastacost 14 (phonetic). We're doing computer models 15 of how people's brains deform during 16 surgery in response to brain tumors. 17 Q. And would that be in adult 18 patients or pediatric patients? 19 A. The initial modeling will be 20 in adult patients. 21 Q. And when you say initial, 22 you mean subsequently there may be some 23 expansion into children? 24 A. The goal is to come up with 25 a universal computerized approach to</p>
<p>Page 3</p> <p>1 SAMUEL NEFF, M.D., after 2 having first been duly sworn, was 3 examined and testified as follows: 4 EXAMINATION OF 5 SAMUEL NEFF, M.D. 6 BY MS. CARUM: 7 Q. Would you please state your 8 full name for the record. 9 A. Samuel Neff. 10 Q. Dr. Neff, I already 11 introduced myself. My name is Anna 12 Carulas and I represent the Cleveland 13 Clinic in this matter. 14 It is my understanding that you 15 have been identified as an expert 16 witness on behalf of the Plaintiff is 17 that correct? 18 A. Yes. 19 Q. What I'd like to do is just 20 begin by talking a little bit about 21 your background and then we will get 22 into your actual opinions in this case. 23 As I mentioned, Ms. Tosti has 24 been kind enough to provide me with a 25 copy of your CV, the date of which is</p>	<p>Page 5</p> <p>1 determining how far brains can be 2 deformed and under what circumstances 3 the deformation leads to stresses that 4 are unacceptable. The initial focus is 5 what happens when tumors are removed, 6 but the goal is to create a clinical 7 tool that would be usable in all sorts 8 of operations. 9 Q. Now, I know we're here today 10 at one of your two offices; is that 11 correct? 12 A. Yes. I have offices. I'll 13 just explain to save the trouble of 14 asking a bunch of questions. 15 This is an office where I 16 practice adult and pediatric 17 neurosurgery. I maintain an office at 18 Graduate Hospital in Philadelphia where 19 I practice adult neurosurgery, and I am 20 50 percent employed by Saint 21 Christopher's Hospital for Children in 22 the practice of pediatric neurosurgery. 23 Q. So half of your practice 24 would be at Saint Christopher's and the 25 other half would be split between</p>

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<p style="text-align: right;">Page 6</p> <p>1 coming here at this office 17 White 2 Horse Pike and Graduate' 3 A. Yes. 4 Q. And what is -- I'm sorry. I 5 didn't catch -- Graduate -- 6 A. Graduate Hospital is a 7 hospital which deals almost exclusively 8 with adults and is in Philadelphia. 9 Q. And is that a teaching 10 institution or a communtty hospital' 11 A. It is a teaching institution 12 as defined by the fact that it has 13 residents in various specialties. 14 Q. So as far as your practice 15 here at this office in Haddon Heights, 16 New Jersey, would that be about 25 17 percent of your total practice? 18 A. Yes. 19 Q. Why don't you just give me 20 an overview as to the nature of your 21 neurosurgical practice? 22 A. The best way to describe my 23 practice is a general adult practice 24 combined with a specialized pediatric 25 neurosurgical practice.</p>	<p style="text-align: right;">Page 8</p> <p>1 includes adult and pediatric. 2 Q. And looking strictly at that 3 25 percent of your total practice which 4 k spine practice, how would you split 5 that up between pediatric and adult' 6 A. The vast majority is adult, 7 95 percent adult -- make that 90 8 percent. 9 Q. Now, you mention that you 10 have research interest, do you spend a 11 certain day out of the week doing 12 research? How does the research fit 13 in? 14 A. I squeeze it in nights, 15 weekends. Now that I have the grant 16 which will pay part of my salary at 17 Saint Christopher's I will be a fixed 18 ten percent of my time. I'll probably 19 end up spending a half day during the 20 week doing research. 21 Q. As one would look at your 22 practice, the '75 percent chunk of your 23 practice which would be operating on the 24 brain and seeing patients in the office 25 regarding --</p>
<p style="text-align: right;">Page 7</p> <p>1 I've maintained a research 2 interest for some years in brain 3 deformation and computer modeling of 4 brain deformation, so that although I 5 don't particularly promote myself as 6 focused on one particular area, I've had 7 a particular interest in patients with 8 problems related to brain deformation 9 and hydrocephalus. In the common scope 10 of neurosurgical practice the only 11 common procedures that I do not do are 12 complex spine instrumentation. 13 Q. Do you do any type of spine 14 surgery? 15 A. Yes. 16 Q. What type of spine surgery 17 would you do? 18 A. Common spine operations such 19 as cervical disc operations, lumbar disc 20 operations, but complex spine operations 21 such as scoliosis and pedicle screws and 22 so forth are not procedures that I do. 23 Q. What percentage of your 24 practice would be doing spine surgery? 25 A. About 25 percent, and that</p>	<p style="text-align: right;">Page 9</p> <p>1 A. I think that the statistics 2 did not work out the way -- I didn't 3 answer the questions that you thought 4 you were asking. 5 Of the practice here on the 6 White Horse Pike a good bit of this is 7 spine, The practice at Graduate 8 Hospital about 50/50 spine and brain and 9 the practice at Saint Christopher's is 10 probably 75 percent brain and 25 percent 11 spine. 12 Q. So let's look at the total 13 picture and what would you say of your 14 total practice would be dealing with 15 children and brain issues? 16 A. About 30 to 40 percent. 17 Q. Now, did you actually do any 18 type of fellowship training in pediatric 19 neurosurgery? 20 A. No. 21 Q. So your training as far as 22 the pediatric aspect would be as part 23 of your general neurosurgery training? 24 A. Yes. 25 Q. I know there are various</p>

DEPOSITION OF SAMUEL NEFF, M.D.

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1 societies that those that practice
2 pediatric neurosurgery belong to that
3 are specifically geared to pediatric
4 neurosurgery, are you a member of any
5 of those?
6 A. I believe I'm a member of
7 the section on pediatric neurosurgery of
8 the American Association of Neurological
9 Surgeons. There is no -- there is a
10 pediatric neurosurgery society -- I
11 forget the exact name -- that I'm not a
12 member of.
13 Q. And given the nature of your
14 practice would you be eligible to be a
15 member of that?
16 A. Actually, I've written away
17 to the Pediatric Neurosurgery society
18 once and didn't receive a reply, so I
19 have no way of answering that question.
20 Q. So what you are telling me
21 is you attempted to become part of that
22 group but never heard back from them
23 basically?
24 A. Yes.
25 Q. And you don't know what the

Page 12

1 shunts, such as what was done in this
2 case, would you approximate for me how
3 many of those you would perform per
4 year?
5 A. I can tell you exactly in
6 the previous six years I performed 172
7 shunt operations up to May of 2001.
8 Q. And how is it you know the
9 exact amount?
10 A. I'm reviewing my data for an
11 article.
12 Q. And so that's something that
13 you have a listing that you've printed
14 off of how many you have performed?
15 A. Yes.
16 Q. And is that something that
17 would be readily available for you to
18 provide to us?
19 A. Yes, within the requirements
20 of patient confidentiality.
21 Q. Redacting patient names?
22 A. Yes.
23 Q. If you would be kind enough
24 to provide that to Ms. Tosti.
25 A. Sure.

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1 specific requirements are for that?
2 A. That's correct.
3 Q. What is the nature of your
4 pediatric neurosurgery practice that you
5 say is 30 to 40 percent of your total
6 practice, you said some is pediatric
7 spine?
8 A. Yes.
9 Q. What type of pediatric --
10 A. The other illnesses, without
11 looking at a complete list right here,
12 I would say in the past few months I've
13 taken care of children with brain
14 tumors, with spinal cord tumors, with
15 hydrocephalus, skull tumors and head
16 injuries and infections.
17 Q. Can you give me an idea as
18 to in a given year how many cyst
19 fenestrations you would perform, or if
20 it's easier per month, however it's
21 easier.
22 A. I would say about two.
23 Q. Two per --
24 A. Year.
25 Q. And as far as placements of

Page 13

1 Q. I would appreciate it.
2 You say you've performed 172
3 shunts, now is that in children or is
4 that --
5 A. Children and adults. I
6 actually was playing with histograms,
7 most of the shunts, the most common age
8 range is between zero to two years.
9 Q. And is that for
10 hydrocephalus?
11 A. Most of the shunts are
12 placed for hydrocephalus. A minority
13 are placed for cysts. Let me clarify
14 my previous answer and say when you say
15 cyst fenestrations, I answered the
16 question in a broad sense of all
17 operations for intracranial cysts, you
18 will probably later get into whether
19 those operations should be fenestrations
20 or shunts, but I was lumping them all
21 together.
22 Q. Meaning what, I don't
23 understand what you are saying?
24 A. Meaning that -- not trying
25 to get ahead of you. In my opinion

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1 shunting is a **better operation for cysts**
2 **than** Fenestration, **so that** that's the
3 primary procedure I usually do for a
4 person, a child **or** an adult with a
5 symptomatic cyst

6 Q. **And** that's the reason for **so**
7 few fenestrations in **your hands**?

8 A. That's the reason for **so** few
9 fenestrations, **yes**.

10 Q. In a given week give me an
11 idea, if you would, how often you are
12 in the operating **room** verses seeing
13 patients in the office?

14 A. I do about five **case5** a week
15 **on** the average and I have -- my big
16 office days are Wednesday and Thursday
17 morning, and then we **squeeze** other
18 patients in and every **other** week I **see**
19 patients on Saturdays over at Saint
20 Christopher's.

21 Q. Now, I note from your CV it
22 mentions that you have privileges at
23 **Wills** --

24 A. That's an old CV. That
25 hospital no longer exists in that form.

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1 Inpatient unit **no longer** exist. The
2 operating **rooms** **no** longer **exist** as owned
3 **by Wills** Eye Hospital. Operating **rooms**
4 owned by **Wills** Eye Hospital are **now** all
5 outpatient **facilities**.

6 Q. **So** you **no** reason to go there
7 because you don't **see** any patients on
8 an outpatient basis there?

9 A. Correct.

10 Q. Prior to it changing from an
11 inpatient to an **outpatient facility** did
12 you actually operate there?

13 A. **Yes**.

14 Q. And how often would you
15 operate there?

16 A. For the period of time
17 **between 1995** and -- probably from July,
18 **'95** to July, **'96**, most of my adult
19 surgery was done there.

20 Q. Did you do any pediatric
21 surgery **there**?

22 A. I did -- no, I did no
23 pediatric surgery there,

24 Q. And what was the reason for
25 this change from an inpatient facility

Page 15

1 It was dosed and converted into an
2 outpatient facility and the building was
3 sold to Thomas Jefferson University.
4 That's of historic interest.

5 Q. But the name is still there,
6 right?

7 A. The entity still assists as
8 of the endowment, but the building has
9 been renamed and is no longer used for
10 eye surgery, **so** at the time I was on
11 staff there it was used for neurosurgery
12 and eye surgery. It ceased to exist
13 in the year **2000**, I believe.

14 Q. The reason I look at you
15 with puzzlement, we were just there a
16 couple weeks ago and I looked out the
17 window and it says Wills Eye Hospital
18 right up on it with bold neon lights.

19 A. They may have changed
20 that -- you were probably there more
21 recently than I was, but the -- not to
22 sound like a TV show, but the Wills Eye
23 Hospital that I had privileges at was a
24 combined ophthalmology neurosurgery
25 facility that no longer exists -- the

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1 to an outpatient facility?

2 A. I do not know why they
3 changed. I think it was a financial
4 thing having to do with the fact that
5 inpatient eye surgery doesn't really
6 exist anymore in the way it did ten
7 years ago.

8 Q. Do you know Dr. Stavino?

9 A. I know who he is.

10 Q. Have you ever met him?

11 A. **Yes**. He was a professor at
12 the University of Pennsylvania when I
13 was a student there from **'80** to **'84**.

14 Q. Since practicing have you
15 come in contact with him?

16 A. I suspect I came into
17 contact with him once or twice during
18 my time when I was doing a lot of
19 inpatient neurosurgery at Wills Eye, but
20 I don't have any specific recollection,
21 any specific encounters.

22 Q. You never referred a patient
23 to him per se?

24 A. I might well have in that
25 **'95** to **'96** period and he might have

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1 referred a patient to me during that
2 **period**, but no one that I've ~~seen~~ in
3 the past few years have I written a
4 letter to him about.
5 Q. Were there any other
6 neuro-ophthalmologists at the **Wills** Eye
7 Hospital that you worked with?
8 A. Well, there was -- let's
9 see, Mark Cohen, Nancy Schwartz and a
10 guy name Thomas Bosley.
11 Q. And did you ever refer
12 patients to any of them?
13 A. Yes.
14 Q. Do you still work with any
15 of those folks?
16 A. I have most contact with
17 Schwa& and Cohen and that just **sort**
18 of fell out. They send me a lot of
19 patients and I would end up talking to
20 them a lot and before you know it other
21 patients got squeezed into conversation.
22 They have offices in a tot of places.
23 It just worked out to be convenient.
24 If I have a good reason to send a
25 patient to Dr. Stavino I wouldn't

Page 20

1 is in Philadelphia, so if it became an
2 issue I would end up referring someone
3 to him.
4 Q. What about pediatric
5 ophthalmologists, do you deal with any
6 pediatric ophthalmologists?
7 A. Yes. All the pediatric
8 ophthalmologists I do is through Gary
9 Diamond at Saint Chris and his new
10 associate whose name I cannot recall
11 right now.
12 Q. Do you deal **actually** with
13 pediatric ophthalmologists more than
14 neuro-ophthalmologists in your practice?
15 A. I deal with pediatric
16 ophthalmologists more than
17 neuro-ophthalmologists, yes.
18 Q. Now, since I just received
19 your CV briefly before coming in here I
20 didn't have a chance to **study** it in any
21 great detail.
22 Have you authored anything that
23 at all would relate to the issues of
24 this case?
25 A. One abstract and two papers

Page 19

1 hesitate.
2 Q. Presently are there any
3 neuro-ophthalmologists that you work
4 with?
5 A. As we sit here right now
6 there are a number of patients I have
7 that have seen a neuro-ophthalmologist,
8 but there is no particular
9 neuro-ophthalmologist that I have any
10 kind of exclusive relationship to, and
11 if a patient I have needs a
12 neuro-ophthalmologic consultation it
13 generally is dictated more by insurance
14 issues and geography than any particular
15 desire to refer a patient to one person
16 or another.
17 Q. Who would **be** the various
18 neuro-ophthalmologists that you work
19 with or refer patients to from time to
20 time?
21 A. There is a guy at the
22 University of Pennsylvania who I would
23 have to look up his name in a patient's
24 chart to tell you who he is. Schwartz
25 and Cohen are **still** around and Stavino

Page 21

1 are relatively germane to this issue.
2 Q. Would you be kind enough to
3 tell us which ones those are?
4 A. On this list referring to
5 this 4-25 copy of the CV, we have
6 number 13 on page five.
7 Q. And is that a published
8 article?
9 A. That's a presentation at a
10 meeting.
11 Q. So that would be the
12 abstract you mentioned?
13 A. Yes.
14 Q. And would you have a copy of
15 that? That's not something that I
16 could get off of MEDUNE, is it?
17 A. No, you couldn't get it off
18 of MEDUNE and I probably don't even
19 have a copy of it anymore. I could
20 probably reconstitute some of it from
21 rough drafts, but it's subsumed by the
22 other articles that I'm going to show
23 you anyway.
24 Q. Okay.
25 A. Numbers nine and ten here on

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1 page seven are published articles on
2 brain deformation and hydrocephalus.
3 Q. And basically is the data
4 contained in nine and ten, that would
5 be the same as what would be in this
6 other abstract lecture?
7 A. Yes.
8 Q. I won't make you go through
9 all of the work of digging it up.
10 You mentioned that when I log
11 onto your website and put in the
12 password and all that that I would have
13 some additional articles, is there
14 anything pertinent that you have
15 published since or lectured on since
16 April of 2001?
17 A. I was probably listed as a
18 coauthor on an abstract that was
19 presented at an engineering meeting by
20 one of my collaborators named Astilios
21 Kereachew (phonetic) at John's Hopkins,
22 but that dealt more specifically with
23 brain deformation, and without getting
24 into the technical details the models we
25 were using don't account for fluid Row

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1 your CV now that I'm glancing at it,
2 you don't have that listed per se, is
3 that because it's a little foggy?
4 A. A little foggy.
5 Q. So as far as an official
6 academic appointment?
7 A. I signed an agreement saying
8 I will conform to the bylaws of this
9 entity, so I do have an official
10 academic appointment. I would have to
11 dig into the records to get you whether
12 it was with MCP Hahnemann University
13 School of Medicine or Drexel, and the
14 best record I could give you is the
15 form that we actually submitted to the
16 INH for the grant, which is the
17 official thing, but to be honest I got
18 a sheet of paper, submitted it and
19 didn't read it very carefully.
20 Q. So from a practical
21 standpoint are you actually using that
22 appointment, do you go out and teach
23 whether didactic or having residents and
24 fellows?
25 A. I'm assigned -- as far as

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1 through the brain, so it isn't
2 particularly relevant to these issues
3 here today.
4 Q. Do you teach at the present
5 time?
6 A. I am assigned to give
7 lectures to residents at Saint
8 Christopher's and at Graduate Hospital.
9 Q. Do you actually have a
10 position at medical school?
11 A. My understanding is that I
12 have a position as a associate
13 professor -- a part-time position as an
14 associate professor in the MCP Hahnemann
15 University School of Medicine. That
16 school of medicine is emerging from the
17 Allegheny Hospital bankruptcy which
18 created turmoil in health care in this
19 area, and so if I'm a little bit vague
20 about where my academic appointment
21 actually is, it's been a little bit
22 vague whether this University is
23 separate from Drexel University or
24 combined with it.
25 Q. I just noticed in looking at

Page 25

1 can tell I'm assigned tasks of teaching
2 residents and fellows as though I
3 was -- the same as the other people who
4 I know who have academic appointments.
5 I'm expected to fill out the
6 same evaluation forms that they fill
7 out. I'm asked to write recommendations
8 for residents for ongoing programs, so
9 that's -- since the salary structure at
10 Saint Christopher's -- I'm actually paid
11 by an entity called Saint Christopher's
12 Pediatric Associates. I don't have a
13 paycheck that I can refer to. I
14 apologize for the foginess, and no
15 disrespect to my colleagues intended,
16 but I really don't care about the
17 details of that. What I care about is
18 doing my research and my operations and
19 so forth.
20 Q. So from a practical
21 standpoint on a given month or whatever
22 who do you teach?
23 A. Most of my teaching is to
24 residents at Saint Christopher's and
25 minority is to residents at Graduate

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1 Hospital.
2 Q. And Saint Christopher's has
3 a neurosurgery residency program?
4 A. They have neither a
5 neurosurgery residency program nor a
6 neurosurgery fellowship.
7 Q. These would **be** what type
8 of --
9 A. Residents in general surgery
10 and residents in pediatrics, some
11 pediatric fellows, and at Graduate
12 Hospital they would **be** residents in
13 general surgery.
14 Q. **Are** you presently involved
15 at all in teaching any neurosurgical
16 residents?
17 A. I'm asked to present cases
18 at ground rounds at Medical College of
19 Pennsylvania every week. Attending the
20 presentation are residents from an
21 osteopathic neurosurgery program, but I
22 don't know my exact status with
23 relevance to that program. I'm not
24 currently teaching any residents in an
25 allopathic neurosurgery residency

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1 program.
2 Q. So the extent of teaching
3 neurosurgical residents would **be** in the
4 didactic form, this lecture form that
5 you give?
6 A. Actually, a case presentation
7 form.
8 Q. Like the ground rounds type
9 of thing?
10 A. Yes.
11 Q. And how often do you do
12 that?
13 A. Every week.
14 Q. And you go there or they
15 come to you?
16 A. I **go** there. We have a
17 multi-hospital meeting; Medical College
18 of Pennsylvania, Hahnemann, Saint
19 Christopher's and Graduate, all the
20 attendings get together and present
21 cases with the residents.
22 Q. Now, Saint Christopher's is
23 strictly a pediatric hospital?
24 A. Yes.
25 Q. And how many neurosurgeons

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1 would there **be** on staff at Saint
2 Christopher's?
3 A. There are probably five
4 listed on staff but **essentially** all the
5 pediatric neurosurgery is done by the
6 chief of pediatric neurosurgery and
7 myself.
8 Q. And who is that?
9 A. Joseph Piatt, P-I-A-T-T.
10 Q. And then there is three or
11 so others listed but they practically
12 speaking --
13 A. They have privileges and
14 they are qualified and their role is to
15 fulfill some of the former requirements,
16 which require if Dr. Piatt and I are
17 both in the operating room there would
18 **be** somebody else to call if an injured
19 child came in.
20 Q. **And** Dr. Piatt is full time
21 at Saint Christopher's?
22 A. Yes.
23 Q. And is he actually what
24 would **be** considered a pediatric
25 neurosurgeon?

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1 A. He has done a fellowship in
2 pediatric neurosurgery, yes.
3 Q. **As** far as dealing with the
4 type of problem that Kevin Kiss had,
5 which was an arachnoid cyst?
6 A. **Yes**.
7 Q. How often do you deal with
8 situations like that?
9 A. About once every month to
10 once every **two** months.
11 Q. And you've looked at
12 actually his films in this case?
13 A. Yes.
14 Q. It's my understanding that
15 he had a large arachnoid cyst?
16 A. That's correct.
17 Q. How would you characterize
18 it, if one would **say** Dr. Neff, what was
19 the size of this from --
20 A. Large or very large.
21 Q. And what would your
22 experience **be** with seeing **cysts** of that
23 size; is it unusual?
24 A. That's one of the largest
25 cysts I've ever seen. I can't **say** it's

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1 the largest cyst I ever saw but it's
2 large or very large, larger than most
3 Q. And in a given year do you
4 wen see one dose to that size?
5 A. Probably see about one a
6 year dose to that size.
7 Q. Do you know how it is, Dr.
8 Neff, that the Kiss' attorney found you
9 in this case?
10 A. No, I don't. I think I got
11 an e-mail message from them.
12 Q. Do you know whether or not
13 they had initially contacted someone
14 else who referred them to you?
15 A. I don't know.
16 Q. Do you know whether or not
17 there was any referral based -- do Dr.
18 Stavino and Dr. Piatt know each other?
19 A. Probably, because Dr. Piatt
20 was also a student at the University of
21 Pennsylvania a few years before I was.
22 Q. Do you know if Dr. Piatt was
23 initially in this mix as far as looking
24 at this case?
25 A. I know that he wasn't.

Page

1 Q. That he was not?
2 A. That he was not.
3 Q. So you were contacted
4 directly from whom?
5 A. He think this law firm.
6 Q. And tell me what you were
7 told at that time?
8 A. Oh, I have no recollection
9 of what I was told at that time. I was
10 asked to review a case and I said sure,
11 I'd be happy to look at the case but
12 I'll give you my honest opinion and
13 that's that.
14 Q. Give me an idea as to how
15 often you review matters like this?
16 A. I probably get one e-mail
17 every other month or maybe between every
18 other month and every fourth month I
19 get an e-mail from someone looking for
20 someone to look at a case.
21 Q. And I'm obviously not as
22 techie as you are but how would one
23 find your e-mail?
24 A. They could get it from my
25 web site, so if someone went to a

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1 search engine and were looking for
2 neurosurgeons it would come up. There
3 is nothing on my web site that implies
4 that I would perform any type of legal
5 consultation, so someone would have to
6 make that call themselves.
7 Q. Have you ever dealt with Ms.
8 Tosti or Mr. Becker, anyone from their
9 firm before?
10 A. At some point they asked me
11 to look at another case. I have no
12 recollection whether it was before or
13 after they asked me to look at this
14 case.
15 Q. And what was the nature of
16 this case, do you recall?
17 A. Am I allowed to say?
18 MS. TOSTI: I'm not
19 sure if it's a case still pending or
20 not. You can tell the subject matter
21 but beyond that I would not have you
22 say anything else about it.
23 A. Stop me when you want. It
24 was a child who underwent a spine
25 operation and ended up with an

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1 unexpected neurologic deficit after that
2 operation.
3 Q. And did you agree to serve
4 as the expert for them?
5 A. In my view of these things I
6 agreed to look at the case and give
7 them an opinion about it, and whether
8 someone, you know, likes my opinion or
9 not, that probably determines whether or
10 not it goes beyond that.
11 Q. Did you actually author a
12 report?
13 MS. TOSTI: At this
14 point he's not going to answer anymore.
15 I'm not sure if this is a case that's
16 pending or not. I'm not going to have
17 him jeopardize -- it may be from our
18 other office. Doctor, please do not
19 answer any additional questions. Do you
20 know if the case is still pending or
21 not?
22 THE WITNESS: I don't
23 know.
24 MS. CARULAS: I guess the
25 problem is how do we know that and how

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1 do I subsequently say it's a --
2 MS. TOSTI: He's told
3 you the subject matter of the case, but
4 as to whether he's authored a report,
5 etcetera, if it's a pending case you
6 are not entitled to that information.
7 For all I know it could be with your
8 office, so at this point I don't know
9 anything about the case and he's not
10 going to answer any additional
11 questions.
12 Q. Here's the question I'm
13 going to ask, and I need to find this
14 out one way or the other. I think this
15 is a fair question. In your assessment
16 of the case did you advise their office
17 that you felt the defendant deviated
18 from acceptable standards of care or in
19 your opinion did he not deviate from
20 standards of care?
21 A. I advised him that he did
22 not deviate from the accepted standards
23 of care.
24 Q. And so that's the last
25 contact you had?

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1 A. Like I said and Ms. Tosti
2 said, the status of that case is a
3 little vague right now.
4 Q. You say that you receive an
5 e-mail every --
6 A. Few months.
7 Q. How often would you say you
8 actually review cases? Give me an idea
9 in a given year how many cases you
10 would review?
11 A. Two or three.
12 Q. And how many depositions,
13 processes like we are doing right now
14 have you given?
15 A. This is my second in a
16 plaintiffs and I've probably given a
17 deposition or two in a defense
18 situation, although one of them was for
19 a bar that was being sued.
20 Q. Have you ever testified on
21 behalf of a defendant physician in a
22 medical negligence case?
23 A. I don't think so but I've
24 given opinions. Let me elaborate on
25 that answer. When these law firms

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1 e-mail me they often don't -- so far I
2 don't think they ever specifically state
3 whether they are for the plaintiff or
4 not. My goal is to improve the tort
5 process by providing a good answer.
6 Now, you can give people a good answer
7 and they can use it or not, but my goal
8 is to at least provide people with a
9 good answer. Probably some of the
10 people I never hear back from who are
11 people who didn't like the answer that
12 I gave them, and that's the best that I
13 can do.
14 Q. So as far as going through a
15 process like this where you have
16 actually defended the care of a
17 physician, can you think of any such
18 circumstances?
19 A. I don't think I have.
20 Q. So you say as far as
21 actually in a situation such as this
22 where you proposed opinions critical of
23 the defendant doctor, this would be the
24 second time?
25 MS. TOSTI: At

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1 deposition?
2 A. At deposition, yes.
3 Q. What was the first case
4 about?
5 A. The first case was about a
6 man who had a broken neck and was taken
7 -- in a car accident -- and was taken
8 to an emergency room. Due to a
9 combination of unfortunate circumstances
10 the doctors who knew he had a broken
11 neck didn't tell the doctors who were
12 taking care of him he had a broken neck
13 and he was sent home and deteriorated
14 and became partially paralyzed.
15 Q. And where was that case
16 venued?
17 A. I don't know exactly. One
18 of the defendants was Cooper Hospital,
19 so I presume it was somewhere in this
20 area. In that case I was a treating
21 physician for the -- a subsequent
22 treating physician for the patient, so I
23 sort of stumbled into it.
24 Q. Have you ever testified at
25 trial?

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<p style="text-align: right;">Page 38</p> <p>1 A. Yes. Actually, I'm going to 2 amended my previous answer and say this 3 is the third time that I've been 4 deposed in this circumstance. I 5 testified at trial in a civil case 6 where I was the Plaintiff; in a murder 7 case where I was an expert witness; in 8 a product liability case where I was an 9 expert witness; and in one medical 0 malpractice case.</p> <p>1 Q. Was the one medical 2 malpractice the case we just discussed? 3 A. The one case I skipped over 4 was a case where a patient was injured, 5 developed an injury during a ulnar nerve 6 operation, and this is another case 7 where I was a subsequent treating 8 physician and was asked to provide an 9 opinion. There was a question of 10 whether or not the operation had been 11 indicated. 12 Q. So that's the one you 13 testified in court? 14 A. That's the one that I 15 testified in court.</p>	<p style="text-align: right;">Page 40</p> <p>1 all of your -- you are presently in 2 actual private practice' 3 A. Half in private practice and 4 half employed by Saint Christopher's. 5 Q. How long have you been in 6 the private practice? 7 A. Since 1995. 8 Q. And this disagreement you 9 had with an employer, when was that? 10 A. Well, I was employed by 11 Cooper Hospital from 1991 to 1995 and 12 when I left there was a little 13 disagreement. 14 Q. And then you went into 15 private practice? 16 A. After I left Cooper Hospital 17 I went into private practice. I was 18 solely in private practice until about 19 1999 when I was partially hired by 20 Saint Christopher's. 21 Q. And what was the nature of 22 you leaving Cooper Hospital? 23 A. Disagreement over 24 reimbursement not to be -- are you 25 going to ask more questions about this,</p>
<p style="text-align: right;">Page 39</p> <p>1 Q. And where was that case 2 from? 3 A. Baltimore, at least that's 4 where I went to testify. 5 Q. And you were a subsequent 6 treating physician and also gave 7 opinions as to the prior care? 8 A. I became a subsequent 9 treating physician first and then was 10 asked to provide opinions about the 11 prior care. 12 Q. And you criticized the prior 13 care? 14 A. Not -- yeah, yeah. The 15 operation in question was done perfectly 16 well, the question was only the 17 indications for the operation. 18 Q. Now, you mentioned that you 19 were a Plaintiff yourself? 20 A. In a civil case, 21 Q. What was the nature of that 22 case? 23 A. Disagreement over severance 24 pay with a former employer. 25 Q. And I guess I didn't go into</p>	<p style="text-align: right;">Page 41</p> <p>1 because I can just tell you in like a 2 paragraph -- 3 Q. Soundsgood. 4 A. Okay. A large amount of my 5 earnings were being accumulated in an 6 account known to me that contractually 7 was supposed to be dispersed to me 8 after expenses were taken out, however, 9 the hospital began using that money that 10 was earned through my practice for 11 operating expenses or for paying other 12 physicians whose practices were not 13 working out as well, and when it became 14 clear that the hospital never intended 15 to give me that money I left. 16 Q. So as far as the decision to 17 leave Cooper, that was your decision? 18 A. Yes. 19 Q. And then you filed a lawsuit 20 in order to attempt to recoup? 21 A. Correct. 22 Q. And were you satisfied with 23 the outcome of the case? 24 A. Yes. After a seven-day 25 trial the jury found that I was owed</p>

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1 the money and they awarded me the money
2 plus interest. Cooper initially
3 indicated that they were going to appeal
4 but then the U.S. District Court in
5 Philadelphia has a mandatory mediation
6 thing, and the mediator convinced them
7 to give me basically everything the jury
8 had awarded.

9 Q. Why don't you tell me, if
10 you would, it **looks** like you are pretty
11 organized there. Tell me what you
12 reviewed in this case?

13 A. I reviewed the medical
14 records of Kevin Kiss from the Cleveland
15 Clinic, Signature Eye Associates, Kids
16 in the Sun, Bruce Cohen, M.D., an
17 entity called Southwest General and Amy
18 Jeffries, M.D.. I've seen his MRI and
19 CT scans. I've looked at the
20 depositions of Dr. Luciano, Dr. Cohen,
21 Dr. Kosmorsky, of Mr. **Kiss'** parents,
22 of Dr. Marcotty and I've seen the
23 letters from Dr. Boop, B-0-0-P and Dr.
24 Hedges.

25 Q. Do you know Dr. Boop?

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1 personal one-to-one interaction with Dr.
2 Luciano at that time?

3 A. No.

4 Q. So you simply --

5 A. Sat at a table where he was
6 at the head.

7 Q. And how many people were at
8 that meeting?

9 A. 30.

10 Q. And what was your impression
11 of Dr. Luciano?

12 A. **Seemed** like a **perfectly**
13 reasonable person. He was well dressed.

14 Q. Did you agree with his
15 points that he was making and **so** forth?

16 A. I don't have any
17 recollection of that.

18 Q. You don't have any
19 recollection that you disagreed with his
20 thinking?

21 A. **Correct.** I think this
22 meeting was more of a planning meeting
23 and strategy meeting **for** the foundation
24 than any particular scientific --

25 Q. Do you know Dr. Luciano by

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1 A. No.

2 Q. Do you know him by
3 reputation?

4 A. No.

5 Q. Have you ever read any of
6 his writings at all on pediatric
7 neurosurgery?

8 A. I may have but I don't
9 recall him particularly being the author
10 of them.

11 Q. Do you know Dr. Luciano?

12 A. **No.**

13 Q. Do you know him at all by
14 reputation?

15 A. Yes.

16 Q. How do you know him by
17 reputation?

18 A. I think he was the head of
19 the hydrocephalus research foundation at
20 a time when I was a member. I went to
21 one meeting that he chaired and then
22 the research foundation sort of
23 dissolved or got subsumed into another
24 entity and ceased to exist.

25 Q. And did you have any

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1 reputation in his writings?

2 A. Yes.

3 Q. In what way?

4 A. I've seen articles written
5 by him from time to time.

6 Q. You would agree that he has
7 significant experience with
8 hydrocephalus and shunts and **so** forth?

9 A. Yes.

10 Q. And in looking strictly at
11 his writings and his experience verses
12 yours, would you agree that he has more
13 experience in that area than you do?

14 A. I'm going to answer the
15 question **two** different ways. I'm going
16 to say that without looking at his
17 writings I presume he's published more
18 papers on hydrocephalus than I have.
19 I'm going to say that without knowing
20 how busy he is, I suspect he's doing
21 more surgery than I am and my
22 understanding is -- but I can't **be** sure
23 of that, however, it's my understanding
24 that he limits his practice to pediatric
25 neurosurgery and it's likely that's he's

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<p style="text-align: right;">Page 46</p> <p>1 doing more pediatric neurosurgery than I 2 am. 3 Q. And I know you read over his 4 deposition? 5 A. Yes. 6 Q. Did you look at his CV at 7 all? 8 A. I don't recall. 9 Q. Do you think you may have or 0 you just don't know? 1 A. I don't know. 2 Q. And you say as far as Dr. 3 Boop you have no knowledge of him one 4 way or the other as far as his 5 expertise? 6 A. As far as I can recall. I 7 may well have read artides that he 8 wrote but the authorship did not stick 9 out in my mind. The main reason Dr. 10 Luciano's authorship sticks out in my 11 mind is because I remember him from 12 that meeting. 13 Q. Do you subscribe to any 14 pediatric neurosurgical publications? 15 A. Yes, I subscribe to</p>	<p style="text-align: right;">Page 48</p> <p>1 A. I don't know who the editor 2 of the latest incarnation of that is. 3 It commutes between my office here and 4 at Saint Christopher's. It may be over 5 there today. Oh, there it is. I don't 6 even know if this is the latest 7 edition. I'd have to see if I have a 8 fourth edition over at Saint 9 Christopher's. 10 Q. So I see here you have the 11 third edition entitled Pediatric 12 Neurosurgery published by the American 13 Society of Pediatric Neurosurgeons, 14 Neurosurgery of the AANS. We talked 15 earlier about the society that you had 16 sent away for, is that the American 17 Society of Pediatric Neurosurgery? 18 A. Yes, I believe so. 19 Q. That's what we were talking 20 about earlier? 21 A. Yes, and the section on 22 pediatric neurosurgery of the American 23 Association of Neurologic Surgeons is 24 the part that I am a member of. 25 Q. So explain that again to me,</p>
<p style="text-align: right;">Page 47</p> <p>1 pediatric neurosurgery. 2 Q. And how often does that come 3 out? 4 A. Once a month. 5 Q. And is that something that 6 you regularly read? 7 A. Yes. 8 Q. What other journals would 9 you subscribe to and read regularly? 10 A. Science and Nature, General 11 Neurosurgery, Neurosurgery, Annals of 12 Neurology, Annals of Internal Medicine, 13 New England General Medicine, Journal of 14 the American Medical Association, 15 Archives Enterology. 16 Q. And I notice you have a 17 fairly extensive library here. Are 18 there any text that are specifically 19 pediatric texts? 20 A. Yes. There is a pediatric 21 neurosurgery textbook put out as a 22 combined work by one of the neurosurgery 23 organizations. It's usually reedited. 24 Q. Who is the editor or author 25 of that?</p>	<p style="text-align: right;">Page 49</p> <p>1 the difference? 2 A. The American Association of 3 Neurologic Surgeons have separate 4 interest sections for members and the 5 society for pediatric neurosurgery is a 6 separate society entirely. 7 Q. And just so we know this, 8 the editors of this, the Editor in 9 Chief is William Cheek, C-H-E-E-K. And 10 there is other section editors; Marlin, 11 McClone, Walker. Besides this 12 particular text would you have any other 13 pediatric neurosurgery textbooks that 14 you refer to from time to time either 15 here or at Saint Christopher's? 16 A. Yes. 17 Q. What would the names of 18 those be? 19 A. I believe there is at least 20 one other book entitled Pediatric 21 Neurosurgery or Principals of Pediatric 22 Neurosurgery. We have two other books 23 over at Saint Christopher's. One of my 24 roles at Saint Christopher's is 25 teaching, so we feel compelled to keep</p>

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1 up-to-date versions of these
2 multi-authored textbooks.
3 Q. So most of the Pediatric
4 Neurosurgery Texts you would be familiar
5 with?
6 A. I think so, yes.
7 Q. How about any textbooks
8 specifically on hydrocephalus or shunt
9 placement?
10 A. I think I've seen -- there
11 is not a large textbook on
12 hydrocephalus. There have been some
13 small monographs on hydrocephalus
14 written and a couple multi-authored
15 books on hydrocephalus written. There
16 is also an international conference held
17 every couple years that puts out a
18 summary of their presentations, and I
19 usually try and get a copy of that as
20 well. Recently there has been a number
21 of FDA reports because the issue of
22 shunt infection has come to their
23 attention, and the issue of shunt
24 malfunction had come to their attention
25 as well.

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1 Q. So most of this literature
2 you would be familiar with to some
3 extent?
4 A. Yes.
5 Q. It's something you would
6 keep up with and read?
7 A. Yes.
8 Q. You just read off for me
9 what you reviewed in this case and
10 before you came in here I leafed
11 through it. Was anything removed from
12 your file?
13 MS. TOSTI: I'll
14 volunteer that I removed our
15 correspondence from our office.
16 Q. So any letters back and
17 forth?
18 A. That's my understanding of
19 what she removed.
20 Q. Anything else to your
21 knowledge that was removed?
22 A. No.
23 Q. Prior to authoring your
24 report in this case did you review any
25 literature yourself?

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1 A. Not that I can recall.
2 Q. Nothing specific for this?
3 A. Nothing specific for this.
4 Q. Did you speak with anyone
5 about this case, what do you think
6 about this or what do you think about
7 that?
8 A. No. After I authored my
9 opinion I may have discussed the case
10 with other neurosurgeons in general
11 terms, not quoting anything.
12 Q. Well, anything that may
13 enter into your mind set may have some
14 bearing on your opinions, whether it's
15 before or after you wrote your report.
16 Did you speak with Dr. Piatt about the
17 nature of this case?
18 A. No. I did mention that I
19 was reviewing a -- he knows Dr. Luciano
20 very well. I mentioned to him I was
21 reviewing a case about Dr. Luciano. He
22 said oh, I eat dinner with Dr. Luciano,
23 and I shrugged and said well, I hope it
24 goes well for him. Not to get into
25 philosophy here, but any time a

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1 malpractice claim occurs is because
2 something bad has happened to someone.
3 Q. I don't understand what you
4 are saying when you said to Dr. Piatt I
5 hope it goes well?
6 A. I was just trying to be
7 nice. In my opinion here obviously in
8 this case it is that Dr. Luciano could
9 have done better, and so what can you
10 say to a friend of a friend who you may
11 end up doing something that he won't
12 feel good about.
13 Q. Besides Dr. Piatt did you
14 talk to anyone else?
15 A. We keep a -- we in our minds
16 keep an anecdotal list of mishaps that
17 can occur with shunts and intracranial
18 pressure, because they unfortunately are
19 all too common and they are easy to
20 lull yourself into. I have in my own
21 mind a mental list of mishaps that I've
22 seen other neurosurgeons get into in
23 shunt situations and this is probably
24 added to my list, so when I'm teaching
25 the residents what to do in this

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1 situation or what to do in that
2 situation and I give them a list of bad
3 things I've seen happen, it will
4 probably include in general terms what I
5 saw happen in this case.

6 Q. So this may be something
7 that you had in your ground round
8 discussions?

9 A. No, I happened to know that
10 particular thing was not done in ground
11 rounds, but bedside teaching is where I
12 would bring this up. Anecdotes are
13 usually not for ground rounds in my
14 opinion.

15 Q. Anyone else that you would
16 have discussed this case with?

17 A. No.

18 Q. Do you know any of the
19 players in this case other than what
20 we've discussed?

21 A. Dr. Hedges I know because he
22 was one of my neuro-ophthalmologists at
23 New England Medical Center where I did
24 my residency, so he was involved in my
25 training from '84 to '91.

1 you know any other players in the mix?

2 A. I saw Allen Cohen's name
3 come up in the mix, and he was one of
4 my attendings where I was a resident in
5 New England Medical Center, so I know
6 him very, very well, but I haven't seen
7 him in a few years.

8 Q. Anything else that has gone
9 into your review of this case other
10 than what you have told me?

11 A. No.

12 Q. We have here a report that
13 you authored which is two pages here
14 dated May 25th, 2001?

15 A. Yes.

16 Q. Besides this two-page report
17 have you authored any other letters,
18 reports in this case?

19 A. Not to my recollection. Of
20 course I've had phone conversations.

21 Q. And when you say phone
22 conversations, that would be with Ms.
23 Tosti or someone from her office?

24 A. Yes.

25 Q. Do you know when it was that

1 Q. You had training both from
2 Dr. Hedges and Dr. Stavino?

3 A. Correct.

4 Q. And what would be the
5 timeframe that you were trained by Dr.
6 Stavino?

7 A. In the course of lectures
8 and neurology and ophthalmology courses
9 at the University of Pennsylvania
10 probably in '83 to '84.

11 Q. And what was your impression
12 of Dr. Hedges?

13 A. I liked him a lot. He and I
14 actually were quite friendly.

15 Q. And he was a very respected
16 neuro-ophthalmologist?

17 A. In his own domain I can't
18 say how respected he is because he was
19 really the only neuro-ophthalmologist I
20 got to know well, but we all were very
21 pleased with the consultative help that
22 he provided.

23 Q. Besides running into Dr.
24 Stavino occasionally, Dr. Hedges and
25 this one meeting with Dr. Luciano do

1 you were first contacted?

2 A. No.

3 Q. And we're in a disagreement
4 as far as whether or not letters or
5 that sort of thing is discoverable, but
6 would those letters that were removed
7 from your file give you an idea as to
8 when it was you were contacted?

9 A. I suspect, but remember the
10 first contact was by e-mail, so it's
11 probably long since deleted. I'm sure
12 when this e-mail came in there was

13 nothing in particular to distinguish
14 from any other and no particular reason
15 for me to place a lot of weight on it.

16 Q. Besides this one report of
19 May 25th, 2001 were there any other
18 drafts to this or was this basically --

19 A. I composed this on the word
20 processor, so this is the draft and the
21 final copy.

22 Q. And I'm sure before today
23 you had a chance to review this again?

24 A. I reviewed it this morning,

25 Q. Is there anything as you sit

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1 here today that you would like to
2 change in your report?
3 A. No.
4 Q. Does this basically
5 encapsulate your opinions in this case?
6 A. Yes,
7 Q. There is nothing glaring
8 that you feel should be added to this
9 report that's not in here?
10 MS. TOSTI: Can I make
11 one addition? He indicated the x-rays
12 were reviewed even though they are not
13 mentioned in here, they were reviewed
14 prior to the time of this report?
15 A. Yes.
16 Q. So you mention a number of
17 things that you reviewed and I saw you
18 had some handwriting there, some of
19 those obviously depositions that you
20 would have reviewed after the fact.
21 The x-rays were something that you
22 reviewed prior to authoring this report?
23 A. Correct.
24 Q. But as far as the actual
25 substance of your report is there

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1 not I really wouldn't address,
2 Q. Okay. I just so I understand
3 and you understands the purpose of
4 coming out here to take your deposition
5 is for me to learn what you plan to
6 testify to later at trial, so it's my
7 understanding that the only opinions you
8 plan to give critical of a health care
9 provider are as related to Dr. Luciano?
10 A. That is correct.
11 Q. Why don't you tell me what
12 your criticisms of Dr. Luciano are?
13 A. Well, the essence of the
14 issue is that after an otherwise -- an
15 apparently completely successful
16 fenestration procedure Kevin continued
17 to have symptoms or even develop new
18 symptoms. So although he was
19 asymptomatic prior to the procedure he
20 developed complaints after the
21 procedure, and initially these
22 complaints were indistinguishable from
23 ordinary complaints that a child might
24 have after this procedure, but at some
25 point it became clear that he was

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1 anything glaring that's not included in
2 there that you think you should have
3 been added?
4 A. No.
5 Q. Why don't you then tell me
6 in your own words your opinions in this
7 case? It is my understanding you are
8 going to say in your opinion Dr.
9 Luciano deviated from acceptable
10 standards of care?
11 A. Yes.
12 Q. Before we get into that, do
13 you plan to offer any opinions as to
14 any other health-care providers other
15 than Dr. Luciano?
16 A. I'm not going to offer
17 opinions about whether or not they
18 deviated from the standard of care
19 because it's outside what I consider
20 myself an expert on. Whether or not
21 they did or not I can't say. Some of
22 the things that I'm going to say that
23 Dr. Luciano could have done could have
24 been done by other people as well, but
25 whether that constitutes a deviation or

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1 having more than the average
2 post-operative difficulties. Additional
3 examinations and evaluations were
4 performed, ultimately additional
5 consultations were obtained with Dr.
6 Marcotty and Dr. Bruce Cohen. Treatment
7 for increased intracranial pressure was
8 started with Acetazolamide, also known
9 as Diamox in some of these reports and
10 ultimately a shunt was inserted. After
11 the shunt was inserted Kevin's symptoms
12 eventually resolved and it was
13 determined that he had a severe visual
14 loss in the left eye and some visual
15 loss in the right eye. The process
16 didn't need to be as prolonged as it
17 was. Kevin could have been checked for
18 papilledema at any point in his
19 post-operative course, and while it's
20 not necessarily the case that every
21 child should be checked for papilledema
22 after every operation, it's certainly is
23 the case that a symptomatic child who
24 complains of headaches that he did not
25 have before and has some fluid under

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1 his scalp flap should be checked for
2 other signs of increased intra-cranial
3 pressure, and one of those checks would
4 be to see if there was papilledema.
5 That may not necessarily need to
6 be done on the first postoperative
7 visit, maybe not even at the second
8 post-operative visit, but at some point
9 during the post-operative course as this
10 gradually escalating cascade of symptoms
11 is developing. Then in February, I
12 believe, when papilledema was
13 additionally noted -- so now there is
14 no question that there is increased
15 pressure in the child's head, the level
16 of treatment should have been more
17 intense because it's well-known that
18 people can go from having papilledema to
19 having papilledema with severe visual
20 loss without a lot of warning. When
21 the papilledema was noted the visual
22 acuity should have been checked, and
23 during Acetazolamide therapy visual
24 acuity should have been checked and at
25 the first sign of visual acuity

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1 high enough long enough to result in
2 this visual loss.
3 Q. Let me see if I can dissect
4 it down somewhat. Let's start off that
5 even following this type of procedure,
6 the fenestration, what are the
7 complaints that a patient can have
8 following that procedure?
9 A. If they are fenestrating a
10 large cyst the child might complain of
11 headaches, might complain of nausea,
12 vomiting, there might be fever. One of
13 the challenges of pediatric neurosurgery
14 is that the post-operative symptoms
15 after this kind of operation can mimic
16 the post-operative complications after
17 this kind of operation.
18 Q. So the normal complaints
19 afterwards --
20 A. Can be indistinguishable from
21 the complaints that would indicate a
22 problem, so that's why I said there is
23 no particular point in time when you
24 can say that on this day Dr. Luciano
25 should have done X, Y and Z, because

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1 deteriorating treatment increased
2 intracranial pressure -- more effective
3 treatment for the for the increased
4 intracranial pressure should have been
5 done. Now, there is no particular
6 standard of care that says you should
7 check intracranial pressure 36 hours
8 after starting Acetazolamide or 72 hours
9 or something like that, but there is an
10 implication that if you are treating
11 someone with Acetazolamide to prevent
12 complications of intracranial pressure,
13 that you are checking for those
14 complications, too. Certainly there is
15 many situations where Acetazolamide does
16 not work and you would put a shunt in
17 to prevent visual loss, so you should
18 be checking frequently for visual loss
19 to make sure there is none so you know
20 when to put a shunt in. My opinion is
21 going to be that through a combination
22 of not assessing the post-operative
23 symptoms correctly and then not treating
24 the increased intracranial pressure
25 rapidly enough, the pressure remained

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1 probably any day you name a reasonable
2 person might say no, the day before or
3 the day after. It's clear that by
4 February even Dr. Luciano was concerned
5 about the way things were going, even
6 if we throw out the parents concerns
7 and so forth, and that would have been
8 the time to act, even if things had
9 been left up to that time that would
10 have been the time to act more
11 aggressively,
12 Q. So, and I think you
13 mentioned in your report you referenced
14 the February 11th visit?
15 A. Yes.
16 Q. And we'll talk about that in
17 a second. Do you plan to testify that
18 prior to that point in time Dr. Luciano
19 was negligent?
20 MS. TOSTI: I'm going
21 to object to the word
22 negligent. Negligence calls for a legal
23 conclusion.
24 Q. Do you understand what --
25 A. Let me answer the question

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1 this way. There is a concept promoted
2 by the American Association of
3 Neurological Surgeons that something may
4 be an unusual or non-standard approach
5 but still considered acceptable by a
6 learned minority of neurosurgeons. I
7 think that most neurosurgeons would have
8 attended to these post-operative issues
9 more assiduously than Dr. Ludano did.
10 I don't think it falls below the level
11 of what some learned minority might have
12 considered acceptable.

13 Q. While you may have done
14 something more and you think others may
15 have there would be a reasonable school
16 of thought, whether it's a minority or
17 majority, that Dr. Luciano's care would
18 fall into, and we're talking up to
19 February 11th.

20 A. There would be a minority
21 who believe that's correct who are
22 deemed to be reasonable.

23 Q. So can we say that you will
24 not be testifying at the time of trial
25 that Dr. Luciano's care, we're talking

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1 however, I would not agree with the
2 characterization of rushing in with a
3 shunt. The other thing to note is that
4 through -- I didn't see it in Dr.
5 Luciano's deposition but in Kevin's
6 mother's deposition there was a lot of
7 talk back and forth between her and the
8 office about keeping Kevin in an upright
9 position, which presumably was done
10 because Dr. Ludano was already
11 concerned that the intracranial pressure
12 was high and that's why he wanted Kevin
13 to be kept with his head up as much as
14 possible. So it's already been a few
15 months after surgery and he's been
16 concerned all that time that the
17 pressure is high but has not looked for
18 papilledema himself, and then upon
19 finding that there is swelling of the
20 optic nerve, which most likely causes
21 papilledema due to the increased
22 pressure, he himself has suspected -- I
23 do not agree with the use of
24 Acetazolamide in that situation, but
25 there is a learned minority that would

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1 about the timeframe now up until
2 February 11th, was unreasonable?

3 A. Correct. Well, fell below
4 the standard of -- into the negligence
5 range.

6 Q. So we know the patient then
7 was referred to Dr. Luciano for the
8 visit of February 11th after Dr.
9 Marcotty, the pediatric ophthalmologist
10 noted the papilledema?

11 A. Yes.

12 Q. Or I think he said --

13 A. Optic disc swelling, I
14 believe.

15 Q. Now, at that point in time
16 Dr. Luciano elected to start the patient
17 on the Diamox. Is there a school of
18 thought that recognizes the use of a
19 medication such as Diamox as opposed to
20 rushing in with a shunt procedure?

21 A. I'm going to say yes and
22 then add a clarification. There is a
23 school of thought that believes that
24 giving Acetazolamide or Diamox is a
25 reasonable approach in this situation,

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1 do that first.

2 Now, what is going on in Dr.
3 Luciano's mind I don't really understand
4 since the problem has gotten worse since
5 surgery and not better and Acetazolamide
6 is generally thought of as a sort-term
7 solution to this sort of problem, but I
8 suspect Dr. Luciano himself suspected an
9 anatomic abnormality which is why he
10 went ahead and ordered an MRI study.

11 Q. What is the role of doing
12 CTs and MRIs after the surgery?

13 A. Well, in certain
14 circumstances imaging studies -- the
15 anatomy can give you answer, for
16 example, if the cyst has resealed itself
17 after the fenestration and is now bigger
18 than it was pre-operatively then you
19 could reliably say that that's the
20 problem that Kevin is having and you
21 could act appropriately. My opinion is
22 that re-fenestration under those
23 circumstances is futile and you would go
24 right to a shunt. It probably would be
25 -- there probably is a learned minority

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<p style="text-align: right;">Page 70</p> <p>1 that would by fenestrating the shunt a 2 second time, but certainly after a third 3 time you would not do that. So can you 4 repeat your question? 5 Q. I was just asking what the 6 role of MRI and CT scans is for 7 monitoring it post-fenestration? 8 A. Positive result on the MRI 9 or CT can lead you directly to an 10 answer. The unfortunate thing is a 11 negative result doesn't necessarily 12 reassure you that things are fine. The 13 optic nerve swelling is a real physical 14 finding, it's swollen for a reason. 15 Now, it could be swollen from multiple 16 sclerosis. Kevin could have developed 17 an entirely new disease separate from 18 what was going on but there is no 19 reason to invoke that. The simplest 20 explanation is that the increased 21 pressure is what is causing the optic 22 nerve swelling. The supporting factor 23 is the fluid accumulating under the 24 scalp flap, which also supports the 25 diagnosis of increased pressure in the</p>	<p style="text-align: right;">Page 72</p> <p>1 fenestrated. 2 Q. And does that give any 3 encouragement as far as how the patient 4 was doing to a neurosurgeon? 5 A. It gives a little bit of 6 encouragement in the sense that the cyst 7 has probably not resealed itself, 8 however, It does nothing for the issue 9 of what is the pressure in the child's 10 head, The pressure could be quite high 11 with the fluid just redistributing in a 12 different area, so you are left with -- 13 as I said, a positive could be very 14 useful and a negative study isn't all 15 that useful. 16 Q. So you are saying that 17 basically that study would not help you 18 at all as far as the evaluation of the 19 amount of pressure on the optic disc? 20 A. Absolutely, that's exactly 21 what I'm saying. In fact, the way I 22 often present it to the residents is an 23 MRI can show you if two things are 24 touching but not how hard they are 25 pressing against each other. The</p>
<p style="text-align: right;">Page 71</p> <p>1 child's head. 2 Q. As you looked at those films 3 he had both an MRI and CT scan 4 initially post-op? 5 A. Yes. 6 Q. And subsequently an MRI? 7 A. Yes. 8 Q. What did the initial CT scan 9 of January tell you? 10 A. It did not look 11 appreciatively different. 12 Q. Different from? 13 A. From the preoperative CT. 14 Q. Was there any improvement 15 whatsoever in the size of the fluid? 16 A. I would have -- can I look 17 at the x-rays? 18 Q. Sure. 19 A. We're talking about the CT 20 of January of '98? 21 Q. Right. 22 A. Yeah, the CT scan of January 23 of '98 shows that the fluid has 24 redistributed somewhat, and that's about 25 what would be expected if a cyst was</p>	<p style="text-align: right;">Page 73</p> <p>1 inability to measure pressures by just 2 looking at MRIs is actually the basis 3 of this research that I was talking to 4 you about earlier, to try and learn how 5 to infer how much brains are shifted on 6 MRIs, what the pressures they are 7 experiencing actually are. 8 Q. Let me just ask you a couple 9 of general questions. What in general 10 are the risks of a shunt placement in a 11 child such as this? 12 A. In a child such as this 13 there are two usual risks, which are 14 the shunt may malfunction, shunt 15 infection is much less of a risk than 16 it used to be, but that's still really 17 more of a nuisance than anything else. 18 With any kind of intracranial surgery 19 there is always risk of bleeding. In a 20 child with a large arachnoid cyst or an 21 adult with a large arachnoid cyst, there 22 would be the additional risk of draining 23 too much fluid off too fast and that 24 can cause blood clots to form on the 25 opposite sides of the head or persistent</p>

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1 headaches or a bunch of different
2 problems.
3 Q. Have you ever seen or heard
4 of visual disturbances after placement
5 of a shunt?
6 A. I've not seen any visual
7 deficits after placement of a shunt.
8 Q. Have you seen a patient have
9 visual deficits after a shunt when they
10 had some complaints of visual
11 disturbances before the shunt?
12 A. Yes.
13 Q. And in what setting?
14 A. In the setting of severe
15 papilledema prior to shunt surgery you
16 may get some visual improvement by
17 reducing intracranial pressure, but you
18 can't guarantee the patient that all the
19 preoperative visual loss will recover.
20 Q. So once the patient has some
21 sort of disc swelling is there a risk
22 of visual disturbances with the
23 placement of a shunt?
24 A. It's easy to tell. You can
25 just measure the patient's visual acuity

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1 before surgery and you can tell them
2 that your vision is going to be this
3 good or better, probably not worse, but
4 not necessarily normal. If the visual
5 acuity is almost normal pre-op it's
6 probably going to be pretty good or
7 normal post-op. If the visual acuity
8 is severely impaired, if 28,000 or down
9 to finger counting, then it's less
10 likely to improve to normal.
11 Q. Is there ever a risk that
12 the placement of a shunt can make
13 visual worse?
14 A. I think the best answer
15 would be no, although you can always
16 invoke the argument that anything can
17 happen. There is no particular way
18 that reducing the pressure in the head
19 should damage an optic nerve,
20 Q. I apologize if I asked you
21 this before, but have you reviewed the
22 report of Dr. Stavino?
23 MS. TOSTI: It hasn't
24 been provided to him.
25 A. I guess not.

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1 Q. And you haven't reviewed his
2 deposition?
3 A. No, I have not reviewed his
4 deposition.
5 Q. And to state the obvious,
6 you haven't spoken with him about this?
7 A. That's correct.
8 Q. This case, when I say this?
9 A. That's correct.
10 Q. What in general are the
11 risks to a patient of having a large
12 arachnoid cyst like Kevin had?
13 A. I don't think anyone can say
14 that. There is a suspicion and a
15 number of neurosurgeons have postulated
16 that these children are increased risk
17 for intracranial bleeding if they hit
18 their head, but there has been no
19 prospective study ever to validate that,
20 so we're really left with a big
21 unknown. I don't think that anyone can
22 answer this question with any kind of
23 scientific certainty.
24 Q. What are the risks
25 associated with performing a

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1 fenestration?
2 A. The small risk associated
3 with any kind of intracranial surgery,
4 which include bleeding, infection, the
5 risk of seizures is thought to be quite
6 low, and the risk that the cyst will
7 close off and need another procedure.
8 Now, in addition, most neurosurgeons
9 mention to patients that hydrocephalus
10 can result from any intracranial
11 procedure, and that's a generally
12 accepted risk of any intracranial
13 procedure.
14 Q. I know we talked about
15 different schools of thought and you
16 certainly acknowledged that in medicine
17 there can be more than one approach,
18 reasonable approach for how to deal with
19 a problem?
20 A. Yes.
21 Q. And that's what we've talked
22 about in these different schools of
23 thought?
24 A. Yes.
25 Q. And you may prefer one

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1 approach and another surgeon may prefer
2 another approach and both can **be**
3 reasonable or acceptable approaches?

4 A. **Based on the current** state
5 of **knowledge**. If the state of
6 **knowledge** arrives at a point where one
7 approach is **clearly** shown to **be** better,
8 **presumably** everyone switches, but in an
9 imperfect state of knowledge reasonable
10 people might **choose** among the range of
11 **approaches**.

12 Q. And even today neurosurgeons
13 are in an imperfect state of knowledge
14 as to this particular problem?

15 A. **Yes**.

16 Q. And the same obviously would
17 have been **true** in '97 or '98?

18 A. **Yes**.

19 Q. Now, you mention that you
20 personally would have performed a
21 shunt -- you may have even performed a
22 shunt at the very **get-go**, and that's a
23 different approach **between** preferring
24 fenestration **verses** shunt?

25 A. **Yes**, but let me go further

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1 old, but I would have at least tried,
2 **tried** to get a visual acuity exam on a
3 seven-year old, which can almost always
4 **be** done with a seven-year old, because
5 that's just the eye chart they do in
6 **school**, and then made a decision about
7 either performing a shunt or **starting**
8 the child on Acetazolamide therapy. In
9 **all honestly**, I would have either
10 decided to put a shunt in or **not**,
11 because I think that the long-term use
12 of Acetazolamide therapy has not **been**
13 shown to be all that helpful, and
14 although there are neurosurgeons who
15 **will treat** a patient for a short time
16 with Acetazolamide, I don't think anyone
17 has ever kept a child like this on
18 Acetazolamide for a year. Seven months
19 post-operatively Kevin has had an
20 escalating series of problems and I
21 would have just recommended shunting him
22 at that point.

23 Q. If Kevin would have had some
24 complaints of headache in a similar
25 constellation of symptoms before the

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1 and just clarify my position would have
2 been I would have recommended nothing
3 for this particular patient.

4 Q. We already talked about
5 looking up towards February **11th** and you
6 are not going to say he deviated from
7 acceptable standards of care, it's just
8 a different approach to dealing with
9 this problem?

10 A. **Correct**.

11 Q. And let me just talk about
12 what you would have done hypothetically
13 had you performed the fenestration and
14 then you saw this patient on February
15 **11th**, '98 as Dr. Luciano did, with the
16 understanding that what you do
17 specifically may not **be** specifically the
18 only standard of care, let's talk about
19 what you would have done. Would you at
20 that point in time have performed a
21 shunt or would you have watched the
22 patient for a while or can you say?

23 A. I think I would have tried
24 to look at the fundi myself. Sometimes
25 that's hard to look at in a seven-year

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1 fenestration procedure, first of all,
2 would that have changed your mind as
3 far as doing something or not doing
4 something if he was symptomatic?

5 A. **Yes**, and I'll go so far as
6 to say most neurosurgeons will recommend
7 a procedure for the cyst, on the
8 assumption that it's the most likely
9 explanation that it should be treated
10 and based on their symptoms.

11 Q. If the patient did have some
12 symptoms beforehand, then had the
13 fenestration and then had some symptoms
14 afterwards, would that change your
15 approach to this?

16 A. **Sure**, and basically if the
17 child is the same as they were before
18 the operation than your suspicion for a
19 post-operative complication is
20 essentially by definition zero, since
21 the child is the same as they were
22 before the operation. At that point
23 let's say you are lumping together
24 headaches and some vague visual
25 complaints and you want to say that

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1 hypothetically those were the same as
2 before the operation, then the first
3 sign of problem is when Kevin complains
4 he can't ~~see~~ out of one eye, I guess,
5 which leads to the ophthalmology visit
6 and then there you are.

7 Q. Now, we know that the day
8 prior to Dr. Luciano seeing this patient
9 he had been evaluated by the pediatric
10 ophthalmologist, Dr. Marcotty, who
11 actually look at the fundi and did a
12 visual acuity, are you aware of that?

13 A. Yes.

14 Q. I know you mentioned that
15 you personally, the steps that you
16 personally would have taken would have
17 been to look at the fundi yourself if
18 you could and should be to get a visual
19 acuity?

20 A. Yes.

21 Q. Anything else that would
22 play a role in your decisions at that
23 point? You said then you probably would
24 make a decision either shunt or Diamox.

25 A. Physical examination and

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1 consequence could be death, not just
2 loss of vision, so everyone does worry
3 about it.

4 Q. So in this particular
5 circumstance we know that Dr. Luciano
6 knew the visual acuity as of the day
7 before based on Dr. Marcotty and also
8 what the pediatric ophthalmologists had
9 seen as far as the fundi and the degree
10 of papilledema?

11 A. Yes.

12 Q. Was it reasonable for him to
13 rely on a pediatric ophthalmologist as
14 far as those two pieces of data from
15 just the day prior?

16 A. The preference would be to
17 repeat it yourself, and the purpose of
18 getting two visual acuities on separate
19 days is to see if they are getting
20 rapidly worse, but in the absolute
21 absence of the inability to do this, if
22 the child is totally uncooperative or
23 some other reason, it certainly is
24 reasonable to rely on the exam from the
25 day before, especially in the situation

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1 neurologic examination of the child, and
2 Dr. Luciano has an advantage over me
3 because he saw the child before the
4 operation, too, so he had the baseline
5 to compare as well. If the child looks
6 well and is running around and playing
7 and a whole bunch of other cues you get
8 when a child is in the office, then
9 your index is sufficient that the
10 problem has lowered. If the child who
11 was previously running around and
12 playing before is now miserable, then
13 there is a tremendous burden on you to
14 find out why the child is miserable.

15 Q. So the answer to the
16 question is basically what you told me
17 would go into your assessment, basically
18 that this physical examination and the
19 general --

20 A. Right, and I'll say further
21 and speak for all pediatric
22 neurosurgeons that this is one of the
23 most difficult assessments that we do
24 because if you fail to diagnose
25 increased intracranial pressure, the

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1 where the risk of missing a problem is
2 high.

3 Q. Hypothetically, had Dr.
4 Luciano attempted to do a fundi
5 examination also this Snellen chart on
6 that date, are you able to state to a
7 reasonable degree of medical
8 probability, and you understand greater
9 than 50 percent, that the results would
10 have been any different than what they
11 were a day earlier?

12 A. I don't think anyone can
13 say.

14 Q. Including yourself?

15 A. Including myself. It could
16 have been worse, and again,
17 hypothetically I'm not saying I know
18 this, it could have been, you know, 50
19 percent of the way to complete blindness
20 the next day or it might have been
21 exactly the same. I don't think anyone
22 is ever going to really know, and you
23 guys will settle this issue based on
24 probabilities. It would have been a
25 useful piece of data to have.

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<p style="text-align: right;">Page 86</p> <p>1 Q. What would your, if you have 2 an opinion, If you don't have an 3 opinion, that's fine, too, that's what 4 I'm here to find out. Do you have an 5 opinion as to what would be more 6 likely? 7 A. I think it's unlikely that 8 you would have seen a major change, but 9 you might get lucky. The same thing 10 with the MRI, it's not likely to show a 11 major useful piece of information, but 12 you might get lucky and see something 13 that clearly tells you what to do. 14 Q. But as far as you being able 15 to say that more likely than not Dr 16 Luciano doing these two pieces of the 17 exam we talked about, looking at the 18 fundi and the visual acuity, whether or 19 not it's more likely than not that it 20 would have shown a change, you are 21 unable to say that? 22 A. I think I'm unable to say 23 that -- yes, I'm unable to say that. 24 Q. Now, you said you would then 25 make a decision as to whether or not to</p>	<p style="text-align: right;">Page 87</p> <p>1 boxes, you can say well, call me 2 tomorrow if you can't see the fine 3 print. In a Seven year old it's a 4 little more complicated and it depends 5 on the seven-year old. I think it 6 depends on how -- it also depends on 7 the parents, how good observers they are 8 and whether you are going to let them 9 subsume some of the responsibility for 10 telling whether things are worse or 11 not. I think that most people would 12 have brought the child back within a 13 week. I might have brought the child 14 back within a couple days. I feel 15 comfortable saying that a reasonably 16 prudent neurosurgeon would have brought 17 the child back in a week or had someone 18 check the visual acuity within a week 19 to make sure Acetazolamide was working. 20 Q. Is there a certain time 21 period that Acetazolamide needs to be 22 given to show some benefit? 23 A. Assuming for the sake of 24 your question that there is a benefit 25 to be had, it should show a benefit</p>
<p style="text-align: right;">Page 87</p> <p>1 start the Diamox or place the shunt? 2 A. And I think everyone would 3 have done something at that point. 4 Q. And we talked about the 5 school of thought recording the Diamox. 6 What, in your opinion, would be a 7 reasonable time for the institution of 8 Diamox? You had mentioned that no one 9 keeps a patient on Diamox for a year 10 and I understand that. What would be a 11 reasonable timeframe for a trial of 12 Diamox? 13 A. It depends on your 14 subjective assessment of how sick the 15 child is, what his other symptoms are, 16 how reliable he and his parents are and 17 a number of interacting factors, 18 Obviously, the goal is to avoid any 19 additional deterioration and if you 20 can't, to detect additional 21 deterioration as soon as possible, 22 thereby minimizing the risk of 23 additional permanent damage. In a 24 15-year old who is complaining that they 25 can't see the fine print on cereal</p>	<p style="text-align: right;">Page 89</p> <p>1 within a few days, but more importantly, 2 the follow-up visit in a week falls in 3 the realm of other things. It may show 4 you nothing. Things may be exactly the 5 same as before, at least it hasn't 6 shown you any deterioration. It's 7 reassuring you that things are happening 8 on a week-to-week time scale and not a 9 day-to-day time scale. 10 (Whereupon, a short break was taken.) 11 BY MS. CARULAS: 12 Q. Before the break we were 13 talking about had you hypothetically 14 started the patient on Diamox what your 15 approach would be, and you would say 16 you would see the patient in a couple 17 days or possibly a week? 18 A. Yes. 19 Q. And what would your 20 evaluation at a week entail? 21 A. Well, you know, the history 22 of the previous week, physical 23 examination, but with a special focus on 24 visual acuity and headaches and the 25 fluid under the scalp flap.</p>

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1 Q. So for a non-brain surgeon
2 tell me what that means? Kevin would
3 come back in and see you and --
4 A. And I would say how are you
5 doing, and a lot of the subliminal
6 things that I was mentioning earlier;
7 does he run in and go to play with the
8 toys, etcetera, etcetera?
9 Q. You just watch him and see
10 how does he look?
11 A. Right. Ask him how he is
12 doing. Seven-year olds will tell you,
13 especially if they know you from last
14 week. I would see if you can get a
15 funduscopic examination on him and test
16 his visual acuity. You might do some
17 distracting things if he's a little bit
18 irritable like weigh him or check the
19 blood pressure.
20 Q. Just to get him to calm
21 down?
22 A. And to distract him and get
23 him to feel more comfortable. I
24 usually reassure the kids at the outset
25 that there will be no needles and that

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1 Hypothetically, had Dr. Luciano seen
2 this patient back in one week are you
3 able to state to a reasonable degree of
4 medical probability what he would have
5 found?
6 A. Yes, I'm able to state to a
7 reasonable degree of medical probability
8 he would have found the patient to be
9 the same or worse than he had been the
10 week before. There is certainly no
11 indication in the medical record, no
12 plausible explanation for him to have
13 been better and then gotten worse later.
14 Q. Can you ever have a
15 fluctuation in symptoms in a situation
16 such as this?
17 A. Sure. For example, if Kevin
18 looks better the next week and maybe
19 even his visual acuity is a little
20 better, that doesn't necessarily mean
21 you are out of the woods. You need to
22 maintain him under a high degree of
23 scrutiny and furthermore now in that
24 situation you know the Acetazolamide was
25 working, so by implication you know that

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1 often helps. The key issues are that
2 you want to address the intracranial
3 pressure as best as you can tell and
4 the surrogates you have for intracranial
5 pressure are the papilledema and the
6 surrogate you have for the papilledema
7 is the visual acuity.
8 Q. And when you check the
9 visual acuity, that's the Snellen chart?
10 A. Yes, the Snellen chart.
11 Now, on the other hand, if the child
12 feels wonderful and looks like a new
13 child it's not necessarily an error to
14 fail to do the Snellen chart, but if
15 the child continues to do poorly and
16 the symptoms have not improved with
17 Acetazolamide, the burden shifts to the
18 physician trying to prove that
19 everything is okay.
20 Q. So say at that particular
21 visit that your assessment is the
22 patient -- let me go back. I don't
23 know whether you plan to give any what
24 we call causation opinions here, but I
25 can go step by step along the way.

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1 the problem was high pressure in the
2 head, so if you know that you are
3 treating a situation where there is high
4 pressure in the head enough to cause
5 papilledema, the level of scrutiny
6 remains the same although the pleasure
7 with the success increases.
8 Q. What could be the other
9 causes? You say if there is
10 improvement than it makes you feel that
11 the Diamox is working so that tells you
12 this was increased intracranial pressure
13 causing the papilledema?
14 A. Yes. To jump on your
15 question, if there is no improvement
16 than either the Diamox is not working
17 or it's not working enough or there is
18 something totally different going on,
19 but still the most likely thing is if
20 the child is the same the next week the
21 most likely two diagnoses is whether the
22 Acetazolamide is not working or it's not
23 working enough.
24 Q. From the mind set of the
25 neurosurgeon, what else could be causing

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1 or could **be** the etiology for the
2 papilledema other than the increased
3 intracranial **pressure**?
4 **A. There are other diseases**
5 that can cause optic nerve swelling that
6 can mimic papilledema, but the prospect
7 of Kevin developing one of them in the
8 middle of this other **illness** with these
9 other symptoms would **be** extremely small.
10 For example, optic neuritis, which some
11 people **feel** is a form of multiple
12 sclerosis can cause optic nerve swelling
13 that can look like papilledema, but
14 there is no reason to think that a
15 seven-year old would get **MS** and no
16 reason to think that he would get it in
17 the middle of this illness, and the
18 normal **MRI** pretty much **excludes** that.
19 Lack of blood flow to the optic nerve
20 common in **elderly** people can give optic
21 nerve swelling **transiently** that is
22 similar to papilledema, but most
23 neuro-ophthalmologists that I've spoken
24 to say they can distinguish that from
25 papilledema due to increased pressure,

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1 and you would expect other signs of
2 vascular disease on fundoscopic
3 examination, not just the optic nerve
4 swelling, **so** I could formulate as a
5 scientific exercise a list, but all
6 reasonable neurosurgeons, I'm sure Dr.
7 Luciano, too, were thinking about
8 increased pressure as the etiology.
9 **Q.** You said that in your
10 opinion while there can **be** some
11 fluctuation in how a patient -- you
12 mentioned that there could be a
13 fluctuation in one's condition, **so** had
14 Dr. Luciano seen this patient back in a
15 week, at that point in time the patient
16 could have appeared better, could have
17 appeared the same or could have appeared
18 worse; is that a fair statement?
19 **A.** Yes, that is a fair
20 statement.
21 **Q.** And for you to be able to
22 say to a reasonable degree of medical
23 probability which of those three would
24 have been reality one week later, you
25 are unable to say that?

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1 **A.** If we define reasonable
2 degree of medical probability as more
3 likely, greater than 50 percent, **based**
4 on what happened to Kevin subsequently
5 and **based** on my experience with this
6 disease process, which is that although
7 there are fluctuations they are usually
8 pretty small compared to the overall
9 magnitude of the disease.
10 **Based** on the fact that any
11 neurosurgeons' examination has its own
12 little error rate as well, I think the
13 most likely thing is Dr. Luciano would
14 not have **seen** much of a difference if
15 he had **seen** him a week later as opposed
16 to what he would have been hoping for,
17 which would have been a significant
18 improvement, a history from the mother
19 that Kevin's behavior had improved in
20 his complaints of headaches, and maybe
21 from Kevin that his eye didn't bother
22 him as much.
23 **Q.** So if there was basically
24 not a lot of difference in that point
25 in time between -- if hypothetically, we

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1 know that this visit was on the 11th of
2 February, say there was another on the
3 18th of February, if it did not show
4 much of a difference what would have
5 been the reasonable options at that
6 time?
7 **A.** Well, let me answer a
8 slightly different question which I
9 think will get to the point you are
10 trying to make, which is that after a
11 series of weekly visits if the
12 papilledema does not resolve and the
13 visual acuity does not return to normal,
14 a reasonable neurosurgeon would judge
15 the Acetazolamide to be a failure and
16 go to a shunt.
17 Now, if the child is perfectly
18 stable by every means you can detect,
19 whether a reasonable neurosurgeon would
20 make that decision at one week, two
21 weeks, three weeks or even four weeks,
22 I cannot say. Probably reasonable
23 neurosurgeons would fall in a
24 bell-shaped curve there. We **know** that
25 prolonged papilledema usually leads to

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1 visual loss, so a reasonable prudent
2 neurosurgeon would not leave the
3 papilledema unattended for a prolonged
4 period of time. And in this context I
5 suspect Dr. Luciano was hoping to get
6 additional information studies he had
7 ordered and the treatment plan got
8 delayed because there was some
9 difficulties in scheduling that.
10 Q. Hypothetically had Dr.
11 Luciano been seeing this patient on a
12 weekly basis during this time period can
13 you say at what point in time -- I
14 think you just answered that you
15 couldn't but I want to make sure -- at
16 what point in time this would be
17 considered a Diamox failure and the
18 standard of care would require a shunt
19 at that time?
20 A. Assuming the exam is exactly
21 the same, reasonable people might
22 differ, and I think that most
23 neurosurgeons would consider it a
24 failure within the month in the presence
25 of visible papilledema, but that

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1 presupposes the visual acuity stays the
2 same. Although we talked about
3 fluctuations you certainly want to see
4 an equal number of positive and negative
5 fluctuations. The first negative
6 fluctuation you might call a fluctuation
7 and the second one in a row you have to
8 start to question. Also, in Dr.
9 Luciano's mind -- and also there are
10 the issue of the fluid under the scalp
11 flap, which Dr. Luciano can examine and
12 we can't here. Finally, in his mind
13 I'm sure there is the issue of he wants
14 to put the MRI information together with
15 this clinical information in order to
16 make a decision. Now, I suspect that
17 if in his mind he was thinking that if
18 the MRI showed hydrocephalus of the
19 standard variety that he would put a
20 shunt in and that would be that, but he
21 sort of -- I can't get into another
22 person's mind, but I think the clinical
23 plan is sort of paralyzed at this point
24 because the imaging study isn't obtained
25 and everything just got stalled.

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1 Q. Was it reasonable for Dr.
2 Luciano to want that additional MRI to
3 look at the picture of this patient?
4 A. Yes.
5 Q. And we know that the patient
6 became claustrophobic and had a
7 difficult time proceeding with that
8 procedure, are you aware of that?
9 A. I saw that in the record,
10 yes.
11 Q. Have you ever seen that
12 happen with children?
13 A. Sure.
14 Q. The fact that that
15 circumstance happened, you would agree
16 we can't blame Dr. Luciano for that?
17 A. No, actually I'm going to
18 come down a little harder on that and
19 say that if a study is indicated, it's
20 indicated and one of the things about
21 pediatric neurosurgery, and even adult
22 neurosurgery, too, is sometimes patients
23 have trouble cooperating with the tests
24 that are in their best interest and in
25 adults, even if they really want to

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1 they may be too claustrophobic for an
2 MRI and this is a standard problem with
3 that machine. However, the patients
4 having difficulty adhering to the plan
5 doesn't relieve the physician of the
6 obligation to see the plan is carried
7 out. It's different when a competent
8 adult refuses recommended therapy, but
9 when a child can't cooperate with a
10 plan then there are ways to get the
11 child to cooperate with the plan and
12 additional delays injected by that are
13 something that shouldn't occur.
14 Q. So when this patient became
15 claustrophobic and Dr. Luciano knew that
16 that MRI cannot be accomplished that day
17 what in your opinion did the standard
18 of care require for his evaluation at
19 that six-week point in time?
20 MS. TOSTI: I'm going
21 to object here to your use of the word
22 claustrophobic. I don't know that
23 that's what happened. There was
24 difficulty in carrying out the exam and
25 I agree that Kevin couldn't cooperate

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1 with it, but I don't know that anybody
2 described him as being claustrophobic.
3 A. Let me answer that question
4 in the following way. It is easy to
5 fall into the trap of delaying a needed
6 study because it's difficult to do,
7 however, that is a -- I described that
8 as a trap because it's not some place
9 you want to be. From time to time I'm
10 in a situation where a child can't
11 cooperate with the study and then I
12 need to make a very difficult decision
13 of do we hold the test over and do I
14 call up anesthesia and get them down to
15 do the study then. I've seen other
16 situations where other physicians have
17 acceptable suboptimal studies when
18 sedation would have given a better
19 study. It almost never leads to
20 anything that you are proud of
21 afterwards, and so I have to say that
22 if the study was indicated, it was
23 still indicated when Kevin was unable to
24 hold still for it and therefore it
25 should still have been done.

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1 not when we waited for the next
2 appointment. A delay of a day might
3 have been reasonable, but this is
4 exactly the kind of trap -- the reason
5 I describe this as a trap is because
6 before you know it you've delayed for
7 two weeks to get it scheduled
8 conveniently and then you delayed
9 another two weeks because he couldn't do
10 it, and then before you know it a month
11 has elapsed and no one would have said
12 at the outset it was a good idea to
13 wait a month before figuring out what
14 to do with this child.
15 Q. We had discussed before what
16 would have taken place back in February
17 and you believe an MRI as well? We know
18 this patient had just had a CT scan
19 relatively --
20 A. January 28th.
21 Q. So you believe another study
22 should have been done? And that's fine
23 if you do. I just need to know what
24 your thought is.
25 A. Basically you make a

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1 Q. When?
2 A. When it was ordered. The
3 fact that he's claustrophobic or unable
4 to cooperate does not suddenly make his
5 disease two weeks less urgent.
6 Q. And correct me if I'm
7 misunderstanding, but your opinion is
8 that that same day when he was unable
9 to complete the MRI for whatever reason,
10 we know that the patient then came to
11 Dr. Luciano's office because they had a
12 scheduled appointment and the decision
13 was made to reschedule the MRI and see
14 him again and it ended up being two
15 weeks,
16 A. Yes.
17 Q. And it's your opinion that
18 Dr. Luciano should have sent that
19 patient back that very same day and
20 whatever it takes, get this MRI done on
21 this child and then bring him back in
22 two weeks?
23 A. Actually, it's my opinion
24 the MRI should have been done when he
25 first showed up with the papilledema and

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1 decision whether you believe the child
2 had papilledema two weeks earlier when
3 the CT was done, in which case you can
4 use that CT as useful anatomic data
5 Papilledema can develop in two weeks and
6 you may say that scan looked pretty
7 good but maybe now something is
8 different. Either way that decision
9 goes, you are either -- if you believe
10 that the CT scan from two weeks ago was
11 the relevant one, then you are treating
12 a child who has papilledema and that
13 particular CT and then the MRI, the
14 follow-up MRI is not so relevant. My
15 previous statements are based on the
16 hypothesis that Dr. Luciano was delaying
17 making a decision about how the Diamox
18 worked or would work or whether he had
19 hydrocephalus based on waiting for the
20 MRI to happen.
21 Q. So you are saying if he felt
22 it was important in March --
23 A. Right.
24 Q. You are not necessarily
25 saying that the standard of care

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1 required it on February 11th?
2 A. Correct.
3 Q. Your basic statement is when
4 this patient had a follow-up visit in
5 the end of March --
6 A. Right, and you've decided
7 rightly or wrongly that that's when you
8 are going to get the MRI, but although
9 my opinion is that's the very outside
10 of what people would consider
11 acceptable, certainly waiting another
12 two weeks because it's inconvenient to
13 get the MRI is not within what's
14 considered acceptable. Again, if the
15 child was markedly improved, if the
16 visual acuity was better, if the
17 papilledema had resolved, if his
18 symptoms were much better, if the fluid
19 under the flap were better, if you had
20 any solid evidence that things were
21 going well, then you could say to the
22 parents, well, things look pretty good
23 and he's back in school and he's
24 playing, we will hold off on the MRI a
25 while. Absolutely none of these things

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1 are happening. All of the symptoms are
2 there, all of the complaints. Maybe
3 you could say well, you can the visual
4 acuity yourself when the MRI can't be
5 done to really make sure that no
6 deteriorate has occurred, but that isn't
7 done either in this case.
8 Q. So tell me if I'm rephrasing
9 so we're on the same page here. I know
10 that visit was the end of March. Your
11 opinion is as of that follow-up visit
12 at the six-week point in time, it was
13 March 24th, at that point in time Dr.
14 Luciano should have fully evaluated the
15 patient and/or obtained an MRI at that
16 time, gotten it accomplished?
17 A. Yes, and my hypothesis is
18 that from what I infer from his
19 clinical plan, the plan was to gather a
20 bunch of data along with the MRI and
21 then make a decision about whether or
22 not the Diamox had worked, and then
23 that plan was put on hold for two weeks
24 for no particular reason other than it
25 was inconvenient to get the MRI.

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1 Q. And so up until that point
2 in time, a six-week timeframe assuming
3 that visual acuity had basically stayed
4 the same, would have reasonable?
5 A. Assuming the visual acuity
6 stayed the same, a six-week timeframe
7 would have been reasonable.
8 Q. So then we came back two
9 weeks later and in your review of the
10 records what did Dr. Ludano do at that
11 time?
12 A. I would have to look at the
13 record.
14 Q. I will find it for you to
15 make it easier.
16 A. Continued to have severe
17 headaches and diplopia, which means
18 double vision.
19 MS. TOSTI: This is
20 April 7th.
21 A. So I'm looking at the visit.
22 What can I tell you about it?
23 Q. So basically that's the day
24 that the patient came back, had the MRI
25 and then saw Dr. Luciano?

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1 A. Correct.
2 Q. Was the MRI in your opinion
3 helpful to this whole assessment?
4 A. No.
5 Q. And why is that?
6 A. Well, it shows the
7 distribution of fluid roughly comparable
8 of what was seen on the CT scan and as
9 I stated before, these anatomic studies
10 are useful if they show a distortion of
11 the brain that clearly shows increased
12 pressure in a particular area, however,
13 if they don't show that distortion there
14 still can be a global increase in
15 pressure sufficient to cause damage, and
16 in particular that kind of global
17 increase in pressure characteristically
18 causes optic nerve damage before
19 anything else.
20 Q. Now, based on the fact that
21 this patient had gone now, not quite,
22 but almost two months from that visit
23 of March 11th --
24 MR. TOSTI: February.
25 Q. February 11th. Sorry. At

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1 that point in time Dr. Luciano
2 recommended that this patient have a
3 shunt; is that correct?
4 A. Yes.
5 Q. The patient went to a
6 neurologist?
7 A. Yes.
8 Q. For an opinion prior to the
9 shunt procedure?
10 A. Yes.
11 Q. In your opinion was that a
12 reasonable thing to do, to have a
13 neurologist evaluate the patient?
14 A. I think that it's a detour.
15 Again, I think Dr. Luciano should have
16 checked the visual acuity right then and
17 unless it was really good, admit the
18 kid to the hospital that day and put
19 the shunt in. I don't see a comment
20 about fluid under the flap, maybe it's
21 gone, maybe it's not -- temporal
22 swelling, so there is still fluid under
23 there. Under those circumstances there
24 is -- he had Acetazolamide failure and
25 I would have -- I think it's a waste of

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1 examination prior to the --
2 A. By itself, no, but we can't
3 really tell what the visual acuity was
4 doing at this point. It could already
5 have been much worse, and so did it
6 suddenly decline in the next 24 hours
7 or was it already bad enough? We don't
8 have that information. If I knew the
9 visual acuity was unchanged I would say
10 fine; visual acuity is unchanged, you
11 want to spend a week seeing the
12 pediatric neurologist, that's fine. I
13 can't imagine what he's going to say
14 except the kid doesn't have MS, which
15 you can tell from the MRI, so I can't
16 imagine how it's going to help, but if
17 the child is clinically stable then
18 stable is stable and there is not a
19 rush, but we don't know.
20 Q. Hypothetically had this
21 patient been seen by Dr. Luciano March
22 24th, that's the date that the MRI was
23 cancelled for whatever reason, had he
24 seen the patient that day and had
25 decided let's move forward with a shunt

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1 time to have a pediatric neurologist see
2 him for what's obviously a situation
3 that has increased pressure in the head.
4 Whether it's an error or not, he
5 doesn't even gather the data about the
6 visual acuity, which as I said before,
7 I think is the critical thing here.
8 That's the only thing you worry about
9 when there is global increase in
10 pressure -- well, people can die, but
11 is the loss of visual acuity and it
12 would have been a simple matter to test
13 both eyes at that time.
14 Q. Your recommendation would be
15 admit the patient right then and there
16 or the next day for the shunt
17 placement?
18 A. Yes.
19 Q. And I guess my question to
20 you is, and I think you may have
21 answered it but you may not have, but
22 was it a deviation from acceptable
23 standards of care for him to request a
24 neurologic examination, or for the
25 family or whoever requested a neurologic

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1 at that point in time --
2 A. Yes.
3 Q. -- so that hypothetically
4 this shunt would have been placed
5 anywhere from two to three weeks earlier
6 than it was?
7 A. Yes.
8 Q. Do you plan to give an
9 opinion to a reasonable degree of
10 medical probability that the visual
11 outcome would have been any different or
12 is that something that you plan to
13 defer or what can you say?
14 A. Hypothetically if the shunt
15 had been placed when, in February?
16 Q. Had it been placed two to
17 three weeks earlier, just to have the
18 dates, we know that March 24th was the
19 date that the MRI was cancelled and
20 then we know it was rescheduled for two
21 weeks later.
22 A. And then sometime in April
23 the shunt was put in.
24 Q. So about a three-week time
25 period between that cancelled

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1 appointment and MRI until the time the
2 shunt was placed, if my math is
3 correct?

4 A. Yes.

5 Q. Are you able to state to a
6 reasonable degree of medical probability
7 that the vision would have been any
8 different?

9 A. When the question is
10 narrowed down that narrow I don't think
11 I can say it, but since Dr. Ludano has
12 declined to gather the information about
13 the visual acuity during this period
14 From January on, it's not possible to
15 say exactly when it deteriorated. It's
16 not possible to narrow the deterioration
17 down to a particular two-week period or
18 three-week period.

19 Q. Now, you read over a number
20 of depositions in this case?

21 A. Yes.

22 Q. You read over Dr. Kosmarsky,
23 Dr. Luciano and Dr. Bruce Cohen?

24 A. Yes.

25 Q. Dr. Bruce Cohen, a

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1 plus papilledema will not have a
2 complete recovery even if treated
3 immediately. Visual acuity is really
4 the preferred way for a neurosurgeon to
5 test it because it doesn't require you
6 dilating the eye and it can be done
7 with using -- the pyridine of the test
8 encourages the patient to cooperate as
9 opposed to looking in the fundus, which
10 you are fighting against the patient,
11 especially in a seven-year old.

12 Q. Visual fields are often very
13 difficult to obtain on the --

14 A. Difficult to obtain and also
15 you could have substantial visual loss,
16 important visual loss and still have
17 normal visual fields, so if this visual
18 field was done the way most neurologists
19 do it, which is holding out moving
20 fingers, neurons in the retina to detect
21 a moving finger, that's not nearly
22 enough to have you read, for example.

23 Q. So to you as a neurosurgeon,
24 visual acuity is much more important
25 than visual fields in this setting?

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1 neurologist, has testified that when he
2 saw the patient that one week later,
3 which we know was actually April 14th
4 of 1998, that both he and his resident
5 checked this child's vision and that it
6 was fine. Do you have any reason to
7 doubt that?

8 MS. TOSTI: Doctor, if
9 I could point out to you what she's
10 referring to. I think he testified at
11 this deposition normal visual fields.

12 A. Normal visual fields doesn't
13 really -- isn't really germane to the
14 issue in question. The kind of visual
15 loss that people get from global
16 increased pressure in their head that's
17 easy to detect is loss of visual
18 acuity. And again, no one seems to be
19 gathering that information except the
20 ophthalmologist. Most ophthalmologists
21 will say if a child has three plus
22 papilledema, which is fairly severe,
23 whether that includes hemorrhage or not
24 depends on the individual neurologist's
25 rating scale. Maybe people with three

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1 A. In this setting, right,
2 visual acuity is much more important,
3 that's likely to be lost. That's the
4 thing that -- I'm not going to testify
5 as an expert on this, but that's the
6 thing that's more likely to affect the
7 person's life. Many people get by
8 without a visual field. If you have
9 normal acuity in the other field you
10 can read just fine, but if you lose
11 visual acuity, that eye is useless or
12 useless for reading.

13 Q. Now, Doctor, do you remember
14 Dr. Cohen testifying at all as far as
15 checking the patient's visual acuity?

16 A. No, I do not.

17 Q. He testified that both and
18 he and his resident would have tested
19 this patient's visual acuity and that
20 Kevin at that point in time was seeing
21 well. If that was the case what would
22 that indicate to you?

23 A. Well, if --

24 MS. TOSTI: I'm going
25 to object to your characterization of

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1 the testimony. The doctor has stated
2 his test for visual acuity was from a
3 Snellen acuity chart and I don't believe
4 there has been any testimony in this
5 case Dr. Cohen tested this child with a
6 Snellen Chart.

7 MS. CARULAS: Just for
8 the record, I move to strike counsel's
9 comments, I don't think it's an
10 appropriate objection.

11 MS. TOSTI: If you are
12 asking a hypothetical, that's one thing,
13 but if you are mischaracterizing the
14 evidence in this case to date then I
15 have to object to it.

16 MS. CARULAS: I think the
17 testimony is what the testimony is as
18 far as Dr. Cohen's assessment of this
19 patient's vision.

20 BY MS. CARULAS:

21 Q. Go ahead.

22 A. When people refer to visual
23 acuity they refer to specifically the
24 ability to distinguish fine print or you
25 can describe in terms of angles, the

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1 understanding of the literature and my
2 testimony here is that when monitoring
3 someone for problems with the optic
4 nerve due to increased intracranial
5 pressure, it's better to monitor the
6 visual acuity than the visual field.
7 In my opinion it's more repeatable and
8 it is easier in a less cooperative
9 patient and less variance from examiner
10 to examiner.

11 Q. Now, how did this patient do
12 after the placement of a shunt?

13 A. From what I understand from
14 reading the various things in the
15 records and depositions, by the end of
16 the school year he was fine, with of
17 the exception of complaints of
18 persistent visual problems in the right
19 eye. I saw one notation that he was
20 back in school getting A's, although he
21 was an average student beforehand. I
22 saw another notation that he was fine
23 with some persistent symptoms but they
24 were not nearly as bad as before.
25 There seems to be a general sense

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1 smallest angle that your eye can
2 discern, although there is more to it
3 than that. Visual acuity determines
4 whether you can read something at two
5 feet or five feet or ten feet. Visual
6 fields refers to how wide the particular
7 eye can see. You could have perfectly
8 normal visual acuity and have what's
9 called tunnel vision, only to be able
10 to see a very narrow field out into the
11 distance, and a classic
12 neuro-ophthalmology trick is people who
13 can see a 20-dollar bill at 20 feet but
14 can't tell who is standing in front of
15 them, it's because they have to scan
16 the whole person with this little narrow
17 field of view to pick up the picture.
18 So visual fields refers to that
19 broadness of the field; can you see
20 things in your peripheral vision or not,
21 You could have normal visual fields and
22 have very poor acuity. You can have
23 very good acuity and horrible visual
24 fields or just see with good acuity in
25 one little spot. As it turns out, my

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1 through the records that he was much
2 better after the shunt than before.

3 Q. Now, just so I'm clear, you
4 are not critical of any of Dr.
5 Luciano's technical abilities here in
6 the performance of the procedures,
7 anything of that nature?

8 A. Correct.

9 Q. And so basically we've
10 covered your criticisms of Dr. Luciano?

11 A. Yes.

12 Q. And you do not plan to
13 criticize anyone else in this case as
14 far as any other care?

15 A. Within the scope of I'm only
16 presenting myself as an expert on what
17 a neurosurgeon would do for those parts
18 of this case.

19 Q. And that's just what I
20 wanted to find out, that's what you
21 feel comfortable with because that's
22 your specialty?

23 A. Correct.

24 Q. And it would be
25 inappropriate for you to come in and

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1 establish the standard of care for
2 other --
3 A. For neuro-ophthalmology, for
4 example.
5 Q. Or a neurologist or any
6 pediatric ophthalmologist or anything
7 like that?
8 A. Correct, beyond certain
9 general things.
10 Q. All right. So we've
11 basically covered your standard of care
12 opinions; fair enough?
13 A. As far as I can tell, yes.
14 Q. Now, as far as how Kevin --
15 how his visual loss was diagnosed, do
16 you know how that came about?
17 A. As I recall from the
18 depositions of his parents, he kept
19 complaining about problems seeing after
20 he was otherwise well. I think when he
21 went back to baseball he couldn't see
22 the balls and that led to additional
23 evaluations
24 Q. Now, do you have experience
25 at all with children that have lost

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1 said, the children very quickly learn to
2 avoid those things that require good
3 binocular vision or good vision in the
4 bad eye and don't even miss it, whereas
5 you might pick up the pieces of a pen
6 and put them together and not think
7 anything of it. These children will
8 not bother, they will throw out the
9 pen. That's a crude example how you
10 can easily get around these things.
11 Now, if someone like that had -- and
12 I'm not going to testify about the
13 details of what this disability amounts
14 to, but if someone like that wanted to
15 be a jeweler, he would not be able to
16 do that or, for example, a pediatric
17 neurosurgeon, that would be a
18 significant limitation, although there
19 are surgeons who have vision in only
20 one eye.
21 Q. From a practical standpoint,
22 I think you already testified today,
23 that most children who have lost vision
24 in one eye compensate well?
25 A. It has been my observation

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1 vision in one eye such as Kevin has?
2 A. Yes.
3 Q. How many patients would you
4 have in your --
5 A. I wouldn't even begin to
6 say, because many patients like that, if
7 they had normal vision in the other eye
8 can function in normal life with only a
9 few limitations and they quickly learn
10 to not bother themselves with those
11 limitations, so I'm sure I see two or
12 three children a week in routine office
13 who have essentially no useful vision in
14 one eye.
15 Q. And one of the notes, while
16 the parents testified that the visual
17 loss was discovered because of baseball,
18 I think one of the notes reflected that
19 when Kevin, when the vision loss was
20 detected upon examination Kevin wasn't
21 even aware of it?
22 A. Depending on how the
23 examination was done and depending on
24 how you formulate the question, that
25 would not be surprising at all. As I

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1 that they compensate well, but that
2 observation is made in the context of
3 the pediatric neurosurgery visit. I
4 always teach the residents that parents
5 and children are happy to get out
6 without hearing they need a new
7 operation, and so the level of
8 complaints are toned down a little bit,
9 and certainly children don't bother
10 complaining about things that they are
11 already used to. They graduate high
12 school and go to college, and if
13 someone has a burning desire to be X
14 and can't do it because of vision in
15 one eye, I'm not the person they
16 probably complain to anyway, and I
17 certainly don't include as part of my
18 ordinary database.
19 Q. So basically you deal with
20 so many very, very serious problems in
21 children that as you mentioned, their
22 concern is more operations, life
23 threatening surgery --
24 A. Is my tumor back and so
25 forth, not gee, this weak eye is still

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<p style="text-align: right;">Page 126</p> <p>1 bothering me for ten years.</p> <p>2 Q. As far as giving testimony</p> <p>3 as to what this particular child or any</p> <p>4 child with the loss of vision in one</p> <p>5 eye will be able to do or won't be able</p> <p>6 to do throughout his life, that won't</p> <p>7 be something that you would be giving</p> <p>8 testimony on?</p> <p>9 A. I can answer questions if</p> <p>10 asked, but I wouldn't present myself as</p> <p>11 an expert on the social issues or the</p> <p>12 economic issues related to having vision</p> <p>13 in only one eye.</p> <p>14 Q. That's all I needed to know.</p> <p>15 You would not hold yourself out as an</p> <p>16 expert in that, per se?</p> <p>17 A. Correct.</p> <p>18 Q. And as far as the list of</p> <p>19 occupations, professions, vocations that</p> <p>20 one with vision in one eye verses two</p> <p>21 can or cannot do won't be something</p> <p>22 that you will present yourself as an</p> <p>23 expert on?</p> <p>24 A. Beyond asking particular</p> <p>25 biophysical questions, about what you</p>	<p style="text-align: right;">Page 128</p> <p>1 difficult at all, but there are certain</p> <p>2 narrow areas of this question where I</p> <p>3 would have an expert opinion, but they</p> <p>4 are relatively narrow and don't go to</p> <p>5 the broader issues.</p> <p>6 Q. Do you know whether or not</p> <p>7 the FAA has allowed people with vision</p> <p>8 in one eye to fly an airplane?</p> <p>9 A. I do not know.</p> <p>10 Q. What are the limitations</p> <p>11 that a child or person that has a shunt</p> <p>12 in place chronically, what are the</p> <p>13 limitations that one has with that?</p> <p>14 A. Well, there is no scientific</p> <p>15 basis or accepted, for example, FDA</p> <p>16 limitations. Children on certain drugs,</p> <p>17 the FDA will promulgate certain</p> <p>18 restrictions. If a person gets a</p> <p>19 pacemaker in, the pacemaker manufacturer</p> <p>20 will promulgate certain restrictions.</p> <p>21 In shunts there are no such official</p> <p>22 promulgated restrictions and many</p> <p>23 children with shunts and adults with</p> <p>24 shunts lead entirely unrestricted lives,</p> <p>25 including athletic activities. There</p>
<p style="text-align: right;">Page 127</p> <p>1 mean by binocular vision from what you</p> <p>2 don't, no.</p> <p>3 Q. Now that you opened that</p> <p>4 up --</p> <p>5 A. Let me elaborate a little</p> <p>6 bit. If someone were to ask me, Dr.</p> <p>7 Neff, would a person with vision in</p> <p>8 only one eye be able to put the parts</p> <p>9 of a Rolex watch back together I would</p> <p>10 say no, and I could consider myself</p> <p>11 expert enough to give an expert no on</p> <p>12 that, because I know that putting the</p> <p>13 parts of a watch together required the</p> <p>14 binocular vision that you need two eyes</p> <p>15 for. There are other questions that I</p> <p>16 would not be able to answer and I would</p> <p>17 say I have no idea whether you could be</p> <p>18 a bus driver. Now, in Pennsylvania you</p> <p>19 are allowed to hold a driver's license</p> <p>20 with vision in only one eye, but I</p> <p>21 certainly don't know about Ohio and I</p> <p>22 don't know whether you are allowed to</p> <p>23 hold a commercial license in either</p> <p>24 state, so in that situation I would not</p> <p>25 be an expert. I'm not trying to be</p>	<p style="text-align: right;">Page 129</p> <p>1 are pediatric neurosurgeons and adult</p> <p>2 neurosurgeons who try to encourage</p> <p>3 people to restrict their activities when</p> <p>4 they have shunts in, but there is no</p> <p>5 prospective data supported validating a</p> <p>6 particular set of restrictions or</p> <p>7 another.</p> <p>8 Q. If you had a child like</p> <p>9 Kevin Kins with a shunt in place, I</p> <p>10 know, for instance, he had been told, I</p> <p>11 believe, by Dr. Allen Cohen that he</p> <p>12 wouldn't recommend playing football. Do</p> <p>13 you agree with that or would you allow</p> <p>14 your patients to play football?</p> <p>15 A. Dr. Cohen and I disagree on</p> <p>16 that. My reasoning is that seven-year</p> <p>17 olds will, as Kevin proved when this</p> <p>18 all started, will run around and bump</p> <p>19 their heads no matter what you do.</p> <p>20 Telling them not to do it in the</p> <p>21 structure setting of football is an</p> <p>22 un-validated restriction of their</p> <p>23 activity. I think in the absence of</p> <p>24 evidence a problem should not be assumed</p> <p>25 to exist. Other presumably equally</p>

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1 reasonable people assume in the absence
2 of evidence a problem should be assumed
3 to exist.

4 Q. So again, it's another one
5 of these different schools of thought?

6 A. Correct, without scientific
7 validation for either.

8 Q. What about the loss of
9 vision in one eye. If you had a
10 patient such as Kevin who didn't have a
11 shunt, would you say it's okay in that
12 circumstance for him to play football?

13 A. With appropriate eye
14 protection, sure. These discussions are
15 always held with shunted kids and with
16 not and even for just simple physical
17 education I explain to the parents the
18 pros and cons of it. Some parents
19 choose to restrict their children
20 anyway. One of the things that parents
21 need to think about it is the best
22 predictor of active lifestyle as an
23 adult is an active lifestyle as a
24 child, and the proven health benefits of
25 an active lifestyle as an adult in my

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1 A. Yes.

2 Q. And is it important for them
3 to try to live as much of a normal
4 lifestyle and not necessarily focus on
5 the health issue?

6 A. That's my opinion, but kids
7 are encumbered by the value systems of
8 their parents, so I try to get the
9 parents as involved as possible
10 because -- planning is risk free, and
11 nothing about raising children is risk
12 free, but I need to give the parents
13 enough information to match the risks to
14 their value system. Some people think
15 the risk of not playing high school
16 football is so high that they will
17 accept any health risk for their child
18 so he could play high school football.
19 Other people are exactly the opposite,
20 but families make choices about risky
21 activities for their children all the
22 time and I believe the surgeon's job is
23 to supply them with as much scientific
24 information as you can and help them
25 make a decision they are comfortable

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1 opinion outweigh these theoretical risks
2 of a problem with a shunt as a child,
3 that's an opinion. I explained the
4 pros and cons of each to the parents
5 and I've seen different families make
6 different decisions with the same
7 information.

8 Q. So basically your thought
9 process on this is whether or not they
10 had lost vision in one eye or whether
11 or not they have a shunt in place is
12 the healthy thing for a child to
13 attempt to live a normal life style and
14 not basically make them feel that they
15 are any different?

16 ME WITNESS: Excuse me
17 one second.

18 (Whereupon, a short break was taken.)

19 BY MS. CARULAS:

20 Q. Your mind set on how children
21 should live their lives whether they
22 have a shunt in place or whether or not
23 they had lost vision in one eye is it's
24 important for them to have an active
25 lifestyle?

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1 with.

2 Q. Tell me, have you ever seen
3 a child -- you've told us that this
4 would be one of the biggest arachnoid
5 cysts you've ever seen?

6 A. Yes. Q. Have you ever
7 personally seen a patient develop loss
8 of vision in one or both eyes from
9 chronic papilledema?

10 A. Yes.

11 Q. Tell me the circumstances?

12 A. Pseudotumor cerebri is a
13 disease where the spinal fluid
14 circulation is not normal. High
15 pressure builds up in the head and
16 people get headaches and papilledema and
17 if not treated properly they will always
18 go blind.

19 Q. For neurosurgeons looking at
20 Kevin's situation and then looking at
21 pseudotumor cerebri, I understand the
22 mechanism may be different but are they
23 basically the same concept in dealing
24 with the patient?

25 A. That itself is a

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1 controversial ~~issue~~, but most of what we
2 know about papilledema and the damage it
3 ~~does to people's eyes~~ comes from
4 clinical pseudotumor ~~cerebri~~, first of
5 all, that was where it was -- that's
6 the most common use for Acetazolamide,
7 Diamox and other similar drugs, and
8 that's the easiest situation which
9 demonstrates they reduce intracranial
10 pressure, and in that situation patients
11 are always monitored with visual field
12 exams, but also with visual acuity
13 exams, and they can lose visual acuity
14 quite suddenly if they are not treated
15 properly.

16 Q. So it's somewhat of a
17 similar --

18 A. The issues are very similar.
19 In addition, in Kevin's case there is
20 the issue of, and also this was in the
21 back of Dr. Luciano's mind, I'm sure,
22 is that if he has ordinary hydrocephalus
23 and is this sick he could suffer
24 complications worse than blindness.

25 Q. What is the longest period

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1 by ophthalmologists or
2 neuro-ophthalmologists.

3 Q. Have you ever referred a
4 patient for that?

5 A. No -- yes, actually I have
6 referred a patient to Dr. Bosley at
7 Wills Eye, of whom I spoke earlier. He
8 told me that the long-term success had
9 not been what the initial reports had
10 suggested and he sent the patient back
11 to me for a shunt.

12 Q. So all in all you --

13 A. I've taken care of a couple
14 people that have had fenestrations that
15 failed eventually and they were sent to
16 me because the fenestrations failed.

17 Q. The optic nerve fenestration
18 is not something that you personally
19 would have recommended for Kevin Kiss?

20 A. I wouldn't have recommended
21 it, but certainly if the
22 neuro-ophthalmologist had recommended it
23 I would have said by all means,
24 fenestrate the optic nerve and
25 presumably that will protect the optic

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1 of time that you have monitored a
2 person with pseudotumor cerebri?

3 A. I have some patients that
4 I've been following for years.

5 Q. And do they have
6 papilledema?

7 A. I've never had someone have
8 papilledema for more than a month before
9 we treated it.

10 Q. And when you say treated?

11 A. In one or two cases
12 neuro-ophthalmologists gave the patients
13 Acetazolamide and got it under control
14 and they were fine and in other cases
15 more commonly the way I get involved is
16 I'm sent a patient who has failed
17 Acetazolamide, the visual acuity is
18 getting worse despite that and we put a
19 shunt in.

20 Q. There was some mention in
21 some of the depositions of this optic
22 nerve sheet fenestration?

23 A. Yes.

24 Q. You don't perform that?

25 A. No. Its generally performed

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1 nerves from the papilledema and we can
2 deal with intracranial pressure
3 separately.

4 Q. I think that's it. Thank
5 you very much. Do you actually have an
6 actual fee schedule?

7 A. We have a fee schedule and I
8 feel real bad all of the sudden that
9 you came here without seeing it, because
10 I was sure I e-mailed it.

11 Q. Is that something we can get
12 before we leave so I can have it?

13 A. Yes.

14 MS. TOSTI: He can
15 produce it to me and we will forward
16 it.

17 Q. What we can do is for the
18 time we've been here which is, if you
19 want to round it up to three hours,
20 we've been here two hours and 45
21 minutes, bill me for that time. What
22 I'm going to need is a bill with your
23 tax ID and all that sort of thing. My
24 only last request is if you ever at any
25 point in time review anything more --

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1 A. Regarding this case.
2 Q. Regarding this case that
3 leads you to have any different
4 opinions, please let counsel know that
5 so I'm aware of it, because my
6 understanding when we have here today
7 is that your opinions are what we
8 discussed; fair enough?
9 A. Yes.
10 (Whereupon, the deposition concluded at
11 11:45 p.m.)
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1 ERRATA SHEET
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1 CEFARATTI GROUP FILE NO. 6035
2 CASE CAPTION: KEVIN KISS V.
3 ANDREAS MARCOTTY, M.D.
4 DEPONENT: SAMUEL NEFF, M.D.
5 DEPOSITION DATE: NOVEMBER 19, 2001
6
7 (SIGN HERE)
8 The State of)
9 County of) SS:
10 Before me, a Notary Public in and
11 for said County and State, personally
12 appeared SAMUEL NEFF, M.D., who
13 acknowledged that he/she did read
14 his/her transcript in the above-
15 captioned matter, listed any necessary
16 corrections on the accompanying errata
17 sheet, and did sign the foregoing sworn
18 statement and that the same is his/her
19 free act and deed.
20 IN TESTIMONY WHEREOF, I have
21 hereunto affixed my name and official
22 seal at , this
23 day of , A.D. 2001.
24
25 Notary Public Commission Expires

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