IN THE COURT OF COMMON PLEAS

TRUMBULL COUNTY, OHIO

THOMAS W. MONROE, Individually and as Executor of the Estate of DEBORAH L. MONROE, Plaintiff, versus JOHN MAXFIELD, M.D., et al., Defendants.	CASE NO. 00 CV 2380 JUDGE KONTOS DEPOSITION OF MICHAEL **A.** ODDI, M.D.

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Deposition of MICHAEL A. ODDI, M.D., a Witness herein, called by the Defendant for Cross-Examination pursuant to the Ohio Rules of Civil Procedure, taken by the undersigned, Linda McAnallen, a Stenographic Reporter and Notary Public in and for the State of Ohio, at the offices of Cardiothoracic & Vascular Surgery of Akron, 224 West Exchange Street, Suite 300, Akron, Ohio, on September 10, 2002, at 2:30 p.m.

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Sixth Floor
Cleveland, Ohio 44113

On Behalf of the Defendant Dr. Maxfield:

Michael Ockerman, Attorney at Law
Hanna Campbell & Powell
3737 Embassy Parkway
Suite 100
Akron, Ohio 44333

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I N D E X

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WHEREUPON,

MICHAEL A. ODDI, M.D.

after being first duly sworn, as hereinafter certified, testified as follows:

CROSS-EXAMINATION

BY MR. OCKERMAN:

Q Good afternoon, Dr. Oddi. My name is Michael Ockerman. I'm here to take your deposition today regarding opinions you may hold in the case involving the decedent, Deborah Monroe.

As you know, you have been identified as an expert. I'm assuming that you'll give expert opinions today. Is that correct?

A. Yes, sir.

Q. You've had your deposition taken before?

A. Yes, sir.

Q So you understand the rules, but I'll go over them just briefly. It's important that you speak your answers rather than shakes of the head or shrugs of the shoulders because Linda can't take that down. If I ask you a question that you don't understand, please tell me, and I'll try to rephrase it. Sometimes my questions are not as articulate as they could be. So if you answer the question, I'm going to assume that you

understood it Is that fair?

A. Yes, sir

Q Would you please state your name for the record?

A Michael Anthony Odom

Q And what is your business address?

A. 224 West Exchange Street, Suite 300, Akron, Ohio 44302

(Defendant's Deposition Exhibit 4, Dr Odom's letter/report to Attorney Taylor-Kolis dated January 11, 2002, was marked for identification)

Q Doctor, I'm going to hand you what we've marked as Defendant's Exhibit 4 Can you tell us what that is?

A Yes, sir, that is a letter that forms my response to questions that Attorney Taylor-Kolis had asked me concerning this case

Q And that letter is dated January 11, 2001?

A Yes, sir

Q And what did you have to review prior to writing that report?

A. I had some records involved in the case, namely those from the St Joseph Family Medical Center, the St Joseph Health Center emergency department, the office record of Doctors Richard

and Gloria Cattarlin, and the autopsy report that was dated 18 July '99

Q I'm sorry, Mr Richard and Gloria Cattarlin -- Can we go off the record?

(Discussion was had off the record)

BY MR. OCKERMAN:

Q Doctor, since how've drafted this report, have you drafted another report?

A No, sir

Q Do you have any notes either in handwritten form or computer-generated form?

A No, sir

Q Have you looked at anything else since January 11, 2001?

A I once again reviewed the records that we mentioned in this letter except for the office records of Doctors Cattarlin.

Q Anything else?

A. No, sir.

Q. I see that we have x-rays here

A. I'm sorry, I did have an opportunity to take a look at the PA and lateral chest x-rays that we had taken on Mrs Monroe

Q And when did you first look at those x-rays?

A Earlier today

Q. That was the first time?
A. Yes, sir.
Q. And do they affect or change your opinions in any way?
A. No, sir.
Q. Doctor, how many depositions have you given in the past, total?
A. I would estimate somewhere between ten and fifteen.
Q. And how many of those have been as an expert on behalf of a plaintiff or defendant?
A. Two. Oh, I'm sorry. Plaintiff or defendant?
Q. Yes. Let me just make this clear. I'm going to break this down into depositions you've given in cases for your own patients, for yourself, defending yourself in any lawsuits, as an expert for plaintiff and as an expert for defendant. Okay?
A. Yes.
Q. So the question is how many have you given as an expert total?
A. Estimate ten.
Q. And of those ten, how many were for plaintiff and how many were for defendant?
A. Two for plaintiff and the others for the

defendant.

Q. And how many depositions defending yourself in a lawsuit?

A. Four to five -- five to six.

Q. And how many as a treating physician for one of your patients, meaning that one of your patients may have filed a lawsuit and you were asked to give testimony in regard to the treatment you gave?

A. None.

Q. You have been in prior lawsuits?

A. Yes, sir.

Q. All in Summit County?

A. As a defendant myself or --

Q. Yes, as a defendant yourself where you are named

A. All in Summit County.

Q. And you've been practicing in Summit County for how long?

A. Nineteen years.

Q. You issued a report January 11, 2001. When did you first receive the records to review this case?

A. I would guess about two weeks before that date.

Q. You are a cardiovascular surgeon?

A. Cardiothoracic and vascular, yes, sir.

Q Can we break down your practice? How much cardio, how much thoracic, how much vascular?

A I would estimate 50 percent cardiac, 20 percent thoracic, and 30 percent vascular

Q And in this case where would Mrs Monroe fall if he were treating her in the categories that you treat patients, thoracic or vascular?

A Thoracic

Q Do you know Dr. Maxfield?

A. No, sir.

Q Do you know Dr Shah?

A. No, I don't.

Q Do you know at all the Monroe family?

A No, sir

Q. Do you advertise your services?

A. No, sir

Q Do you have an understanding of the plaintiff's health history prior to her presentation to St Joseph Family Medical Center?

A. Only in what was described as past medical history, namely hypertension.

Q Are you going to give opinions in regard to the standard of care of Dr Maxfield in this case?

A. No, sir

Q. Are you going to give opinions in regard to the

approximate cause issues?

A Yes, sir.

Q Are you going to give opinions as to had surgery been performed and been successful and had Mrs Monroe allowed what her prognosis would have been?

A. To the best of my ability, yes, sir.

Q Any other opinions that you're going to give in this case?

A No.

Q You're not going to give opinions about Dr Maxwell as an emergency room physician?

R No, sir

Q You've had a chance to review the chest x-rays?

A Yes, I have

Q Do you review chest x-rays on a regular basis in your practice?

A Every day

Q Did you look at or request to look at the abdominal CT?

A In my letter from January of 2001 I had requested that, realizing that the report was described as within normal limits.

Q And have you been provided that?

A No, sir

Q. Do you know why?
A. I don't.
Q. Is abdominal CT something that you look at on a regular basis?
A. Yes, with regard to abdominal vascular structures.
Q. Are you going to give opinions in regard to the standard of care of the radiologist who interpreted the chest x-ray?
A. No, sir.
Q. Let's talk about the chest x-ray. Today is the first time you looked at it, correct?
A. Yes, sir.
Q. Although you asked as early as January 11th of 2001 to look at it?
A. Yes, sir.
Q. What do you see?
A. Just looking at this in a methodical fashion, this is a chest x-ray of a young to middle-aged woman. The bony structures look to be within normal limits. The mediastinal vascular structures and cardiac border look to be normal. I don't see any evidence of any pleural effusion or fluid accumulation in either chest cavity. I don't see any evidence of any lung masses or

areas of collapse of any of the pulmonary structures. I would call this x-ray to be within normal limits.

Q. So you've seen the report of the radiologist and you agree with his interpretation?

A. Yes.

Q. And you even have the hindsight of knowing what the autopsy showed?

A. Yes, sir.

Q. You don't see a tortuous aorta?

A. No, 1 don't.

Q. You said that looking at the x-ray it shows a young to middle-aged woman. Is that based upon information on the side or just based upon looking at the x-ray?

A. No, I'm looking at the x-ray.

Q. What is it that indicates that you can tell this is a young to middle-aged woman?

A. I can see breast shadows, implying that this is a woman. And I don't see any evidence of any demineralization or sclerosis of the bones, which means it's probably not an elderly woman.

Q. You have a copy of your opinion ietter there. You say in the first paragraph -- And we'll go through it paragraph by paragraph. Okay, sir?

A. Yes, sir

Q. The last sentence, 'She had initially been evaluated at the St Joseph Medical Center where an aneurysm of aorta was suspected and she was referred on an urgent basis to the St Joseph emergency department '

Where does the information come from, an acute aneurysm of aorta?

A This is the evaluation from the St Joseph Family Medical Center in Howland I don't see the physician's name, I apologize for that, but the last line that says diagnosis says, quote, severe back pain hypertension: rule out aneurysm of aorta, end quote

Q What's not specific as to the location of the back pain?

A Not that particular line higher up in the evalu tion for the initial assessment it says the patient, quote, developed sudden onset of back pain and chest pain by -- oh, no, I'm sorry, back pain and chest, seen by parameds, refused transport or treatment by EMS, end quote

And then further on in that particular description it says nine -- no, it says, quote, severe back pain between shoulders, state pain,

feels like muscle cramps, end quote.

Q. In the next paragraph of your report you say, "Looking at these records in toto, it seems to me that there was very significant and unfortunate miscommunication regarding this patient's suspected diagnosis or at the least a misunderstanding or some misinformation that might have been shared over the telephone between these two medical treatment facilities."

What are you relying on for that statement?

A. The fact that the physician who had seen the patient at I presume an urgent care center in Howland initially, who described back pain between the shoulders and then rule out aneurysm of aorta, sent the patient on to the St. Joseph Health Center emergency department, and the description for the history of present illness in the workup at that facility mentions that the patient complained of, quote, sudden diffuse lower back pain, onset three hours prior to arrival, end quote.

So the initial physician had seen the patient for what he described as upper back pain, and the physician seeing the patient at the

St Joseph emergency department describes lower back pain. So it seems to me that there was some type of disconnect either between the two physicians or in the patient's own described symptomatology from one health facility to the other.

Q So how the patient describes to you the symptoms, is that also important to a physician who's treating a patient?

A. That's of primary importance, absolutely.

Q You go on to say in the next to last sentence, 'It seems to me that the appropriate studies to evaluate lower back pain were obtained, but because of this focus on the lower back area, the actual pathology was prophylx missed '

A Yes, sir.

Q What do you mean by that?

A Meaning that the physician who saw the patient at the St Joseph emergency department did the appropriate studies to rule out what he thought the problem was, namely the abdominal CT scan, thinking that the patient had a kidney stone or whatever So he did the appropriate studies based on what his differential diagnosis was But the actual pathology, as it turns out later

that day, turned out to be a dissection within the thoracic aorta for which the appropriate study wasn't done, primarily because from what I gather the patient didn't complain of upper back pain at that point

Q Now, can you use a chest x-ray as a beginning step in determining a patient who complains about mid back pain between the shoulder blades?

A That should always be the first step, yes, sir

Q And in this case you've seen the chest x-ray and you agree that that is normal?

A. Yes

Q. For a young to middle-aged woman?

A. Yes, sir

Q No pathology that you can demonstrate to us that would account for upper back pain or mid scapular pain?

A Not on the face of it, but retrospectively the mediastinum is borderline widened, you know, what most people describe as about 3 centimeters Any bigger than that may mean pathology I think hers is probably about 3 centimeters But that s only retrospectively And if I saw this x-ray on a woman in my office tomorrow, I'd say it's probably normal

Q And retrospectively still you wouldn't say it's abnormal; you'd say it's at the limits of normal?

A. Yes

Q. And when you say 3 centimeters, can you show me on that film where you're talking about?

A The mediastinum is the middle part of the chest between the two lungs And I'd say you're looking right there So it's about an inch below the heads of the collar bones

Q And o the right-hand side would be the aorta? On your right-hand side, I should say

A On our right-hand side as we face the x-ray, the aorta is on the right side And the aortic contour looks very smooth in that chest x-ray

Q Okay In the third paragraph, you talk about the importance of looking at the actual x-rays studies done including the chest x-ray and CT scan.

A Just to confirm for myself that the studies look to be normal I don't claim to be a radiologist, but we always look at our own x-rays

Q When you say we always look at our own x-rays, what do you mean?

A My partners and I

Q And you weren't provided the CT scan?

A That's true

Q. Did you ask why?
A. I presumed it was because the abdominal CT scan wouldn't offer any information in this case.
Q. Why do you presume that?
A. Because it turned out that there was no abdominal pathology.
Q. You go on to say, "If the thoracic aortic dissection had been diagnosed during the initial evaluation, the appropriate surgical evaluation and operative procedure would probably have followed. Because of the magnitude of the indicated surgery, and depending on the acuity and severity of the pathologic process encountered intraoperatively, it is certainly possible that the patient might not have survived to leave the hospital."

What is it that you're trying to communicate there?
A. Basically that even if the appropriate diagnosis had been made, this operation to correct an acute aortic dissection carries a significant mortality, so the patient might not have survived to leave the hospital anyway.
Q. Let's talk about the location. You know that she died of a dissection, and we know by autopsy

where the dissection was

A. Yes, sir

Q Where was the dissection?

A. It was in the upper portion of the thoracic aorta just a few centimeters below the aortic arch, and that was described in the autopsy report by Dr Platt

Q Can we go to that description there?

A. Yes, sir This is on page 4 of 11 of the autopsy report That was dated I think 18 August '93

Q. You say there is significant mortality with this type of surgery

A. Yes, sir

Q What do you mean by that?

A I mean that approximately 15 to 20 percent of patients who have this operation don't survive thirty days

Q Have you performed this surgery yourself?

A. Yes, sir

Q On how many occasions?

A Probably five to six It's not a very common operation.

Q And of those five to six patients that you've done, how many have survived thirty days?

A Four

Q. For your 15 to 20 percent mortality rate, what are you relying on? Are you relying on your own experience, are you relying on literature?
A. Literature, yes, sir.
Q. Did you do a literature search for this case?
A. No, I did not.
Q. Any specific literature that you can cite to me that would support your statistics?
A. No.
Q. Do you find any textbook in the field of thoracic surgery to be authoritative?
A. There's no specific reference that's authoritative.
Q. What textbooks do you find to be reasonably reliable in regard to thoracic aortic surgery?
A. Well, the ones that are most relied upon are the ones by Frank Spencer, David Sabiston, John Kirklin, and probably the one by Dr. Glenn.
Q. And what about peer reviewed journals, any of those that you find to be reasonably reliable in regard to this issue of thoracic aortic dissections?
A. The ones tnat most thoracic surgeons refer to are the Annals of Thoracic Surgery and the Journal of Thoracic and Cardiovascular Surgery.

Q Is there anything t at you can find one way or the other that would say to us that Mrs Monroe would have survived this surgery, she would not have been one of the 15 to 20 percent that would not have survived?

A. There's no way to predict that for sure, although because of her age, her youth, she certainly would have a greater chance of surviving perhaps than an older patient in his sixties, seventies or eighties

Q So you would point just to her age as being a beneficial factor to mortality?

A. Yes

Q. And you go on to say, 'Also, there are specific potential complications associated with this surgery, and these might well have led to chronic, possible lifelong disability '

A Yes, sir.

Q And in that regard we're talking about morbidity?

A Yes.

Q And what are the percentage of morbidity complications in a patient who suffered a dissection of the thoracic aorta 3 cent meters below the arch?

A The thing that everybody worries about with this

operation is the probability of paraplegia, which occurs statistically in anywhere from 3 to 15 percent.

Q. Isn't it also reported as high as 20 percent?

A. Yes.

Q. What other morbidity complications can occur?

A The primary other morbidity or morbid condition that has the potential for leading to chronic disability would be an intraoperative neurologic event, namely a stroke, that can happen any time you operate on patients who have intraoperative hypotension because of blood loss depending on exactly where this aneurysm or where this dissection is in terms of being able to try to control the aorta above that, it may be necessary to interfere with the blood flow to the left side of the brain.

Q Because we're just 3 centimeters below the arch?

A That's where the dissection was described In order to gain control of the aorta above that level where you can actually work on it, sometimes it's necessary to clamp some of the major branches of the aortic arch

Q And that's because if the rupture or dissection starts at 3 centimeters below the arch, you have

to be a few centimeters above that so that you have an area which you can get good material to sew to?

A. Exactly.

Q And that may necessitate you going above one of the major branches that go to the head?

A Yes, sir.

Q What other morbidity factors are involved in t is type of surgery?

A Those are the primary morbidities that lead to the potential long-term disability The other things we worry about are infection, pneumonia, problems with the prosthetic graft that you have to use to replace the part of the aorta that's dissected, and the potential for blood clots and pulmonary embolism.

Q Do you know what the morbidity percentages are for intraoperative neuro events, such as a stroke?

A I can't tell those off the top of my head I think that for most cardiac procedures what's recognized as an acceptable stroke rate is somewhere between one and two percent

Q We talked about the cases in w ich you've done this surgery -- I'll see if I can find that

Five to six patients, four survived 30 days. How many had paraplegia?

A. I had one man who had what we call paraparesis. He was weak in both of his legs but not paralyzed, and over the course of the next two years with intense physical therapy he did recover significantly.

Q. Was he able to return to the work force?

A. Yes.

Q. Any other complications from the four that survived 30 days?

A. No, sir.

Q. You'd agree with me that in a woman Mrs. Monroe's age that what occurred to her is a very unusual and rare occurrence?

A. I would say extremely unusual, yes, sir.

Q. Would you also say rare?

A. Yes.

Q. What caused this?

A. You have to presume that she had some genetic predisposition to developing aortic dissection and that her hypertension actually caused the dissection to start, meaning she did not have any evidence, as far as I can tell, of what they call a connective tissue disorder that sometimes leads

to aortic dissection. There must have been some aortic pathology to cause the dissection in the first place, but that was not able to be spelled out at the autopsy

Q And when we talk about some genetic predisposition, that genetic predisposition would be throughout her aorta, not just located in the thoracic aorta?

A That's true, but the more common place for dissections to occur in patients who have conditions such as Marfan's syndrome or Ehlers-Danlos syndrome is in the thoracic aorta

Q Do you think that she had Marfan's syndrome?

A There was no evidence for that I don't know if any specific studies were done by the pathologist to determine that, but she did not have the body habitus for someone with Marfan's syndrome Those people are usually tall and slender.

Q What about Ehlers-Danlos syndrome?

A Ehlers-Danlos is pretty much the same They're usually all patients who are slender and either tall or medium height.

Q. Would Mrs. Monroe, assuming she would have survived this, been at risk for dissection of her ascending aorta?

A. I'm not sure anybody can tell that for sure, although certainly if you have a dissection occurring in one part of the aorta and if her hypertension is not controlled extremely well, that certainly sets the stage for further problems in the future, but there is no way to speculate meaningfully on that I don't think.

Q. Did you see from a review of these records whether she was being treated for her hypertension?

A. Since she had a history of hypertension, I presume she was under some sort of treatment. The blood pressure that was mentioned by the EMS or that was recorded by the EMS people was 180/90, and in a 32-year-old that is very high.

Q. Is the life expectancy of a patient who has a previous thoracic aortic dissection decreased compared to one who does not have a repair of a thoracic aorta?

A. I'd have to say that there has to be some decreased life expectancy just because we don't see patients of this age develop these problems. They're usually patients in their sixties and seventies. And there are, as I mentioned, potential problems with the prosthetic graft

that's used to replace this aorta over a twenty- or thirty-year period. But to expect her to have a twenty-year survival following an operation like this I don't think is unreasonable. If she would live to be the expected 77 or 78, I really don't know. Probably not I would say, but I don't know.

Q. Are you saying that there is a certain life expectancy of the graft?

A. Nobody knows what the actual life expectancy of the graft is, because these grafts have only been used since the late '60s. So in terms of beyond thirty years, I don't think anybody has any information about that. But the Dacron grafts hold up over a long period of time. Unless she developed problems in other portions of her aorta, I don't think it would be unreasonable to think that she'd have a life expectancy of twenty or thirty years whether or not she'd had any neurologic complications from the operation.

Q. You specifically cite Dacron graft.

A. Yes.

Q. Is that the only type used?

A. That's the only kind that we use at this hospital, but there are other surgeons who use

Gore-Tex grafts for situations like this. Primarily in the thoracic aorta, I believe most surgeons still use Dacron.

Q. And Gore-Tex, is that the interwoven type and Dacron is more of the --

A. Actually Dacron comes in both woven and knitted. And for the thoracic aorta very commonly we use a woven Dacron graft, whereas in the abdominal aorta we use knitted Dacron. Gore-Tex is -- there's no knitted versus woven; it's just the Gore-Tex material.

Q. In a patient with hypertension at a young age -- and when I say young I'm saying in the thirties -- is their life expectancy decreased versus someone who does not have hypertension beginning in their thirties?

A. If their hypertension is not well controlled, I'm sure they have potential problems with cardiac problems, renal problems, peripheral vascular blockages, and the potential for hypertensive strokes.

Q. And in this case prior to Mrs. Monroe's death in July of 1999, would you say her hypertension was well controlled or not well controlled?

A. I don't know that. I don't know what her

previous blood pressures were. On that day her blood pressure was elevated. But there are so many things that can cause elevated blood pressure in terms of anxiety in the specific situation you find yourself in. If her blood pressure were consistently 130/90, that would lead to problems without question.

Q. Well, doctor, correct me if I'm wrong, but I thought that the dissection would occur because the patient had uncontrolled hypertension for more than a short period of time. And when I say short period of time, I'm talking, you know, a few days. Is that accurate or not?

A. I don't know if anybody can speculate meaningfully on that at all. The predisposition is there. Whether or not a single episode of uncontrolled hypertension could do something like that or whether it needs to be uncontrolled for a fairly long period of time, I don't know.

Q. How do you define uncontrolled hypertension?

A. I think anybody who has a sustained diastolic pressure, a lower pressure, greater than 80 is uncontrolled. Anybody who has a systolic pressure that consistently is over 150 or 160 is probably uncontrolled. And we used to think that

it was acceptable to have a systolic pressure of 100 plus your age, so that an 80-year-old person could have a pressure of 180 and that would be acceptable now I think in recent years it's been recognized that it's far better to have a systolic pressure down in the 120 to 140 range, and the diastolic should never consistently be over 90

Q You said you had an opportunity to review her family practice records What did they show her blood pressure to be?

A I don't have the records from the office of Doctors Catterlin in this packet right now, so I don't know if I had access to any previous blood pressure measurements Let me just check one thing here There is no mention of whatever medications the patient might have been on before her passing that now

Q Doctor, looking through Dr Catterlin's records, I see in 1993 she had a blood pressure of 150/86, in January of 1995 I see 140/101, in June of 1995 I see 128/88 Off the record

(Discussion was had off the record)

BY MR. OCKERMAN:

Q. The blood pressures I just read came from

Dr. Satterlin's office chart, but please go ahead and go through those and see if you find what I said to be accurate

A Yes, the blood pressures recorded in these office notes are as you mentioned

Q And would that indicate to you that she was well controlled or not well controlled?

A Again, a spot blood pressure measurement doesn t mean a whole lot to me unless it's extremely high That's why I usually -- I have ex patients go to the fire station a couple times a week and get their blood pressures measured

The pressure of 150/86 in September of 1993, if that were consistently that high in a person at the -- Can we go off the record for a second?

Q Sure.

(Discussion was had off the record)

(The court reporter read the preceding answer as follows: The pressure of 150/86 in September of 1993, if that were consistently that high in a person at the --)

A. -- age of 32 years, then I would say that that is not very well controlled The blood pressure

recorded in January of 1995 of 147/100 is certainly higher than you would like to see and would tell me that either the patient had a significant anxiety level that day or needed additional blood pressure control medicine

Q And when was January of 1995. I think there's a later visit in June -- or maybe I'm mixing up my dates Yes, June of 1995 with a blood pressure of 128/88

A That certainly is better controlled I'd still like to see the diastolic pressure a bit lower than that. But that's certainly acceptable

Q So is she well controlled in June of 1995?

A. Yes.

Q. With a diastolic pressure of near 90?

A As long as it doesn't go any higher than that And I presume that Dr Catterlin or some other physician was checking that periodically Or if the patient had a blood pressure measurement device at home, and there are many of those available now that are pretty reliable, then she can keep track of that herself

Q Do you see any records from Dr Catterlin after June of 1995?

A. No, sir.

Q Do you know whether she was checking her blood pressure on a regular basis?
A I don't know.
Q Can you tell whether the dissection is a chronic dissection or acute dissection?
A. Unless there were some findings at the time of autopsy that would indicate that she had some kind of inflammatory reaction around her aorta. I don't think there's any way to tell that I think she obviously had an acute problem that day got whether or not that occurred that day or had been brewing for some time. To my knowledge there's no way to determine that for sure.
Q And it's your opinion that these dissections -- and correct me if I'm wrong -- can occur in two ways over a period of time with chronic hypertension, uncontrolled hypertension, you can have a dissection?
A. Yes, sir.
Q. And the second way is with acute hypertension you can have a dissection?
A. Yes, sir.
Q. Does it vary with the numbers, the blood pressure numbers? I mean would you expect if the patient

truly had a blood pressure prior to July of 1999 that was consistently with the diastolic number -- which is the important one, correct?

A Yes, sir

Q Being at or near 90, would that cause a dissection over time?

A I would say probably not I think it would have to be higher than that

Q How much higher?

A This is just speculation on my part If it were consistently over 100, I think that's bad too high If you have a genetic predisposition to develop aortic dissection and you have a diastolic pressure consistently that high, then with time that could certainly cause a problem. There is a clinical condition of chronic dissection also And the treatment for a chronic dissection of the descending thoracic aorta is judicious control of blood pressure and not surgery.

Q Do you believe that she was dissecting outside of her aorta when she presented to St Joseph Heal th Center on July 1st, 1999?

A I have to think that on the basis of the symptoms that she presented with that the dissection at

least, if it didn't initially occur that day, progressed significantly the day that she had her symptoms on the 16th of July.

Q. What would be the signs and symptoms of a dissection of the aorta on a chest x-ray? I mean what would you expect to see on a chest x-ray?

A. I wouldn't expect to see much of anything abnormal on a plain chest x-ray.

Q. Why do you say that?

A. Because again the dissection implies that there is a separation of the layers of the aortic wall, and until it actually starts to become dilated you wouldn't expect to see anything.

Q. And how does -- and again I understand what you're saying. You're saying that the dissection occurs on the interior layer of the aorta?

A. Yes, sir.

Q. And then the aorta, because there's a crack in the interior layer, blood is allowed to get into the intermediate layer and begin to expand the aorta?

A. Yes, sir.

Q. What is it that causes the pain?

A. It's kind of a tearing effect of the blood flow under pressure actually inside the aortic wall

where it's not supposed to be.

Q. Does the aorta have pain sensors?

A. The outer layer of the aorta, yes, the adventitia does.

Q. Do you know when it ruptured, and when I say ruptured, I mean through the inner layer, intermediate layer and the outer layer?

A. Well, a rupture causes acute loss of blood, so that didn't happen until after she left the St. Joseph Health Center, which was sometime after 3 p.m. I believe by the record.

Q. And how soon after she left St. Joseph's did she die?

A. I don't have the death certificate here to tell me what the time of death was.

Q. So you don't have any information before you that indicates the time that she died; you just know that she died on the following day, July 17th?

A. Yes, sir. She was discharged from the emergency department at St. Joseph's at 6:25 p.m. And then I have a statement related to the autopsy that says date of death July 17th, but I don't have a time of dearh, no, sir.

Q. Will morbid obesiry decrease a patient's life expectancy?

A. It certainly has the potential to, because at times obese patients are more likely to develop blood clots in the deep leg veins, have a higher incidence of potential for pulmonary embolism after open minor operations, have a greater probability of progressive degenerative joint disease involving the lower extremities and low back, and obesity is one of the cardiac risk factors that is known to lead to the development of coronary disease.

Q Will obesity have any factor on thoracic dissection?

A Not to my knowledge.

Q Will obesity have any factor on hypertension?

A Yes, obesity and hypertension are connected as well as what is termed dyslipidemia or improper ratio between certain types of cholesterol, and obesity of itself can actually lead eventually to hypertriglyceremia or a form of diabetes that oftentimes will resolve once the patient is able to lose some weight.

Q. The autopsy indicates that the intima of the aorta reveals mild arteriosclerosis What does that mean to you?

A. It means that even at age 38 she had begun to

have some atheromatous changes in the walls of her vessels.

Q. Is that unusual for a 38-year-old?

A. Not in our society.

Q. And the beginning of atherosclerosis is the beginning of plaque formation?

A. Yes, sir.

Q. They also indicate she had moderate coronary arteriosclerosis. What does that mean to you?

A. It means that she has early formation of atherosclerotic plaques in her coronary arteries.

Q. And will that decrease one's life expectancy?

A. It certainly can if those continue to progress beyond an early stage.

Q. Would you say that hers is more advanced than you would expect in a 38-year-old?

A. I think it would really depend on other factors also. I mean if she were chronically hypertensive and relatively inactive in terms of having a fairly sedentary lifestyle without any kind of exercise program and already has established hypertension, then I don't think that — would be unusual for me to see in a 38-year-old.

Q. We know that she was working.

A. Right.

Q And you're saying her hypertension was controlled?

A I'm saying that I don't know that her hypertension -- I'm saying that back in 1995 when the last blood pressure measurement that we have was 128/88. If it stayed there on blood pressure control medicines, it's okay, it's well controlled. The two blood pressure measurements that were recorded in the record on the 16th of July were 180/90 and 150/100, and those are both higher than they should be

Q They also show focal myocardial interstitial fibrosis. What is that?

A. That's kind of a nonspecific finding that may mean that she has some what's called small vessel disease involving certain layers of the myocardium or the heart muscle or other fibrotic process that we can see in anybody who develops any kind of heart rhythm abnormality that is not related to coronary disease at all So that of itself doesn't really tell me much

Q What about nuclear hypertrophy?

A I'm not sure what that means That's a microscopic finding I'm not sure what the implications of that are

Q Then they talk about the aorta shows a dissecting aneurysm with rupture

A. That s a misnomer The dissection is a process that's totally separate from an actual aneurysm. When a dissection begins to cause aortic wall dilatation or expansion, when the blood within the tissue layers causes dilation, then you can call that an aneurysm just because it's dilated in comparison to a normal aortic diameter. But an actual aneurysm is a totally different pathologic process.

Q And what's the pathological process of an aneurysm?

A Progressive weakening and dilation of the entire aortic wall involving all three of the layers It's much more common than an aortic dissection. It more commonly occurs in the abdominal aorta below the origins of the arteries that go to the kidneys.

Q And what caused the progressive weakening of all three layers?

A. It's a genetic predisposition that is thought to occur in maybe two percent of everybody because of a decrease in one of the chemicals present in the aortic wall called elastin

Q So are you disagreeing with the coroner here where he calls this a dissection aneurysm with rupture?

A Not necessarily because everybody calls it a dissecting aneurysm. But a dissection and an aneurysm are two separate things If you have a dissection that leads eventually to a dilation or expansion of the aorta, then people call it a dissecting aneurysm even though it's not really an aneurysm to begin with

Q The person who did the autopsy also found left ventricular hypertrophy What's the cause of that?

A. Chronic hypertension.

Q Controlled or uncontrolled?

A You know, I'm not an internist I would say it possibly is uncontrolled over a period of time But patients who have chronic hypertension predictably will develop some degree of left ventricular hypertrophy, although in a person this age that's not very common.

Q So based upon the blood pressures that we have, based upon findings on autopsy, do you think the patient had controlled hypertension or uncontrolled hypertension?

A. The only thing that would lead me to believe that her blood pressure was probably uncontrolled over a consistent period of time would be the ventricular hypertrophy. The changes in the arterial and aortic walls, the atheromatous changes, the arteriosclerotic changes, may or may not be related to blood pressure at all.
Q. But the hypertrophy of the left ventricle would --
A. Strongly suggest it, yes, sir.
Q. Strongly suggestive of uncontrolled hypertension?
A. Yes.
Q. Just so I'm clear, you're not going to give any standard of care opinions in regard to Dr. Maxfield's treatment of the patient?
A. That's correct.
Q. What are your fees for reviewing cases?
A. For reviewing records, medical charts, $250 an hour.
Q. And for depositions?
A. $350 per hour.
Q. And for trial testimony?
A. $2,500 per day.
Q. How many hours have you spent in this case?
A. My initial review was for an hour and a half, and

the current review was for less than an hour.

Q. How many cases do you review on an average per year?

A. Usually two at the most.

Q. Have you ever given a deposition in the past involving a dissection of the thoracic aorta?

A. I gave a deposition regarding a traumatic rupture of the thoracic aorta, but that's not the same pathologic process as a dissection. I can't recall having given a deposition for this particular problem, no, sir.

Q. Doctor, are there any other opinions that you're going to express that we haven't already talked about?

A. No, sir.

Q. Have I given you a fair opportunity to answer al of my questions?

A. Yes.

MR. OCKERMAN: I don't have any further questions.

MS. TAYLOR-KOLIS: He'll read the deposition. Can we have a waiver though on the seven days?

MR. OCKERMAN: Yes.

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(Whereupon, signature was not waived by the witness.)

- - - - - -

(The deposition was concluded at 3:47 p.m.)

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W I T N E S S C E R T I F I C A T E

I, MICHAEL A. ODDI, M.D., hereby certify that I have read my deposition taken on September 10, 2002, in the case of Thomas W. Monroe, Individually and as Executor of the Estate of Deborah L. Monroe, versus John Maxfield, M.D., et al., consisting of forty-six pages, and that said deposition is a true and correct transcription *of* my testimony.

_____
Michael A. Oddi, M.D.

Dated this _____ day of _____, 2002.

Sworn to and subscribed before me this _____ day of _____, 2002.

_____
Notary Public

My commission expires _____

LM

CERTIFICATE

STATE OF OHIO,)
) SS:
SUMMIT COUNTY.)

I, Linda McAnallen, a Stenographic Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named Witness, MICHAEL A. ODDI, M.D., was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony so given by him was by me reduced to Stenotype in the presence of the witness; and that the foregoing is a true and correct transcription of the testimony so given by him as aforesaid.

I further certify that this deposition was taken at the time and place in the foregoing caption specified.

I further certify that I am not a relative of, employee of or attorney for any of the parties in the above-captioned action, that I am not a relative of or employee of an attorney of any of the parties in the above-captioned action, that I am not financially interested in this action, and that I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined by Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Akron, Ohio, this 17th day of September, 2002.

Linda McAnallen, Notary Public
My commission expires August 20, 2005.

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AKRON, OHIO 44302

January 11,2001

Donna Taylor-Kolis Co. L.P.A.
Third Floor-Standard Building
1370 Ontario Street
Cieveland, Ohio 44113-1701

RE: Case of Deborah Monroe

Dear Ms. Taylor-Kolis:

As we discussed on the telephone recently, I have had an opportunity to review the records that you sent me regarding the case of Mrs. Deborah Monroe, These records consist of the record from the St. Joseph Family Medical Center; the St. Joseph emergency department, the office record of Drs. Richard and Gloria Catterlin; and the autopsy report dated 18 July, 1999. The patient expired secondary to exsanguination due to ruptured aortic dissection within the proximal portion of the descending thoracic aorta. She had initially been evaluated at the St. Joseph Family Medical Center, where an "aneurysm of aorta" was suspected, and she was referred on an urgent basis to the St. Joseph emergency department.

Looking at these records in toto, it seems to me that there was very significant and unfortunate miscommunication regarding this patient's suspected diagnosis, or at the least, a misunderstanding or some misinformation that might have been shared over the telephone between these two medical treatment facilities. The initial evaluating physician was apparently impressed by this patient's upper back pain which suggested the pathology that ultimately caused her death, and the evaluating physician or physicians at the second treatment facility focused on "sudden diffise lower back pain". It seems to me that the appropriate studies to evaluate lower back pain were obtained, but because of this focus on the lower-back area, the actual pathology was probably missed. Again, these are my impressions based on the information submitted for my review.

As we discussed on the telephone, it would also be very important to be able to review the actual x-ray studies done at the St. Joseph emergency department; specifically I would be interested in the chest x-ray and the CT scan.

If the thoracic aortic dissection had been diagnosed during the initial evaluation, the appropriate surgical evaluation and operative procedure would probably have followed. Because of the magnitude of the indicated surgery, and depending on the acuity and severity of the pathologic

DEFENDANT'S
DEPOSITION
EXHIBIT
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ODDI

process encountered intraoperatively, it is certainly possible that the patient might not have survived to leave the hospital. Also, there are specific potential complications associated with this surgery, and these might well have led to chronic, possibly lifelong disability. However, it can certainly be argued that the rupture of the aortic dissection **was** the proximate cause of this patient's death, and that a timely operation would likely have been successful.

If you need any further information from me regarding this case, or if you are able to obtain the above-mentioned radiographic studies, please contact me at any time.

Sincerely,

Michael A. Oddi, M.D. FACS FACC

MAO/kf