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

IN THE COURT OF COMMON PLEAS

MARLA J. SPREADBURY, et al , :
plaintiffs :
:
vs. : Case No. 1998CV1681
1998CV0589
MERCY MEDICAL CENTER, et a .,:
defendants :

Deposition of MICHAEL ODDI, M.D., a witness herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Constance Campbell, a Notary Public within and for the State of Ohio, at the offices of Michael Oddi, M.D., 224 West Exchange Street, Akron, Ohio, on MONDAY, OCTOBER 18TH, 1999, commencing at 1:00 p.m. pursuant to agreement of counsel.

APPEARANCES:

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I N D E X

WITNESS: MICHAEL ODDI, M.D.

PLAINTIFFS' DEPOSITION EXHIBITS	MARKED
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(IF ASCII DISK ORDERED, SEE BACK COVER)

MISS KOLIS: Doctor, for identification purposes on the record, as you know we've been introduced, my name is Donna Kolis, I've been retained to represent Marla spreadbury in the action currently pending against Dr. Cawthon and Dr. Tawil only.

My purpose today is to discover what facts you know, what opinions you hold.

Have you had the opportunity 'to give a deposition in the past as an expert witness?

THE WITNESS: Yes, I have.

MISS KOLIS: This is Melissa Berry who is a couple minutes late, she is also on this case.

I gather if you have given a deposition before you would probably be familiar with the deposition rules, I like to go over them.

I gather you are acquainted with a concept that you must answer every question verbally?

THE WITNESS: Yes, I am.

MISS KOLIS: I gather you understand the testimony you are giving under oath today is just as if you were in a courtroom?

THE WITNESS: Yes.

MISS KOLIS: If I ask questions

which you do not understand, please be advised I prefer you tell me you don't understand the question. Can I secure that agreement from you?

THE WITNESS: Yes.

MISS KOLIS: Do you understand I'll rely upon the answers that you give me today to represent that which you will testify to at trial?

THE WITNESS: Yes.

CROSS-EXAMINATION

BY MISS KOLIS:

Q. Having said that, I would like to know what you brought with you this afternoon to the conference room in anticipation of whatever questions I might ask.

A. This is my copy of the inpatient record from Mrs. Spreadbury dated from the 23rd of September, '97 to 3 November, encompassing the radiology report, pathology report and operative reports, progress notes, and nursing notes from that hospitalization.

Q. In addition to the Mercy Medical Center records have you seen any of Mrs. Spreadbury's subsequent records, either from rehabilitation or medical records of her current condition, any other medical records relating to this patient?

A. No.

Q. Will you be offering an opinion at trial in this matter based on your review of the hospital records which you already mentioned as to whether or not there is a reduction in the life expectancy of this patient due to her outcome?

A. Realizing that is really impossible to speculate very objectively on, there is some decrease in life expectancy in a paraplegic patient because they tend to develop repeated urinary tract infections and sometimes other systemic infections. Over and above that it depends on what kind of daily care they get. I have seen paraplegics with family care live for a normal life expectancy. I've seen others put in institutions that don't live long at all. Theoretically there will probably be some decrease, It is pure conjecture what that might be in terms of years.

Q. Do you know Dr. Began?

A. Doctor?

Q. Began?

A. No.

Q. Are you familiar with the physiatrists that work at the Crystal clinic?

A. No,

Q. Do you yourself work with physiatrists to work with patients postparaplegia?

A. Not really work with them as such in terms of patients to at the Edwin Shaw Rehabilitation Hospital when I have a case that involves physical rehab, yes.

Q. In addition to the medical records which you brought to the deposition this afternoon, Doctor, do you have a correspondence file between yourself and Mr. Treadon?

A. No.

Q. So there isn't one in existence?

A. That is correct.

Q. First of all, do you know since there is no correspondence file, when were you initially contacted to review this matter?

A. I can't recall the exact date. Mr. Treadon may have some more information regarding that. It had to be some time before the 1st of January. The reason I say that is because I had pneumonia in January, I know I didn't have a chance to review the records I really wanted to at that time until everything got better. It was sometime before the 1st of the year.

Q. I just want to know if you recalled it.

Not in any particular order here let me ask you this: In addition to those medical records, have you reviewed the deposition testimony of anyone

involved in this case?

A. Yes.

Q. Whose deposition have you reviewed?

A. Drs. Telesz, Cawthon, Tawi1, Chryssos, Kralik, and Donahue.

Q. I gather you would have been given Dr. Donahue's deposition testimony today or Friday?

MR. TREADON: I can tell you it was delivered to his office on Friday.

A. I picked it up on Saturday. I was out *of* town Friday, yes.

Q. You were able to review this this past weekend?

A. Yes.

Q. Have you reviewed the testimony that was given by Mr. or Mrs. Spreadbury?

A. No, I have not.

Q. Have you read the testimony *of* the neurosurgeon, Dr. Sos?

A. No.

Q. Have you reviewed the chest films *for* September 23rd and September 24th of Mrs. Spreadbury?

A. Yes.

Q. when I say chest films, first of all I gather you looked at the x-rays?

A. The plain chest, yes.

Q. Have you also reviewed the CAT scan for September 23, 1997?

A. Yes, I did.

Q. When did you review that?

A. I would say probably sometime in June or July, then again within the past three weeks.

Q. Fair enough. Let's go back to some logical order.

Prior to meeting you today I had asked Mr. Treadon for a copy of your CV, it was duly delivered today. I believe you are once again providing me a copy of the same; is that right?

A. That's correct.

MISS KOLIS: We will mark that.

(Plaintiff's Exhibit A marked for identification.)

Q. So I don't forget the question, I always forget what I really want to ask, as the court reporter was marking the Exhibit conversation ensued whether or not you reviewed Mrs. Spreadbury's subsequent treatment records at Edwin Shaw.

Doctor, today as you sit here can you tell me whether you have yet reviewed those?

A. I have not.

Q. Therefore any opinion you render to me today

regarding the issues in this case would not include information that was contained in those records; that's a fair statement?

A. That is correct.

Q. Briefly, if we could go through your background and training.

First of all, Doctor, you can identify your CV. Is it accurate for me to state that contained in your CV are no publications?

A. That's correct.

Q. Have you published, I just don't know about it?

A. Yes.

Q. Do you have a CV that contains your publications?

A. I need to update the CV. There are only a few, it's not an extensive number at all.

Q. would you extend me the courtesy, please, through Mr. Treadon, of providing me with what I would consider to be a complete CV with all the publications, abstracts, articles, things of that nature?

A. Yes.

Q. Have you authored any book chapters in any surgery textbooks?

A. There was a fairly thick textbook, was not a surgery textbook, basically a general medicine textbook called The Five Minute Consultant, I was asked to author

a chapter on thoracic outlet syndrome years ago. That is the only even brief book chapter I authored.

Q. You indicated the title of the book is The Five Minute Consultant, did I hear that correct?

A. Yes.

Q. What is the nature of the material contained in that book, general subject matter?

A. Basically a compendium of every medical subject imaginable. It's got a two page blush on each thing, there are two pages on chronic lymphocytic leukemia and on aortic insufficiency, thoracic outlet syndrome.

Q. Was it written to be of use to the emergency room physician or just general medical?

A. General medical book. It is available both in hard copy as well as CD rom.

Q. Publication year on that book, if you recall it?

A. They do another one every year.

Q. Have you continued to author the section?

A. It's been unchanged for the last six or seven years, they continue to publish it every year.

Q. Knowing you are going to be submitting to me your complete CV I need to ask the question up front: Are there any articles that you authored that have to do with the treatment of traumatic transected descending aorta?

A. No, ma'am.

Q. Are there any articles, abstracts, listed on your CV that deal with the issues that present themselves in this case?

A. No.

Q. That's fair enough. Thank you very much.

You have testified on previous occasions as an expert witness, fair statement?

A. Yes, ma'am.

Q. Whom have you worked for previously in terms of expert testimony?

A. I can't really recall the specifics of the case. It was just a single case about three years ago in Stark County, the attorneys worked for Buckingham, Doolittle in their Canton office. I honestly can't remember the name.

Q. Do you know who you worked for in that office?

A. No.

Q. Do you know which doctor you were testifying on behalf of?

A. No, I can't remember.

Q. Do you recall the facts of the case?

A. I really can't.

Q. Is that the only time that you have done any medical/legal expert work?

A. No, I was asked to render an opinion about a case involving a wrongful death suit in a patient who had an esophagectomy for esophageal carcinoma years ago, at that time I worked for an attorney who was with Jacobson, Tuschman, Maynard and Kalur in Cleveland, the case did come to trial, but summary judgment was given by the judge before I ever had a chance to testify.

Q. So in that case you were also retained to testify on behalf of the thoracic surgeon but your testimony never became necessary?

A. Yes.

Q. Other than these two instances that we're discussing where you've given testimony, have you periodically provided medical consulting services to attorneys that represent the doctor, i.e. have they called you to run facts by you, get your opinion on a situation?

A. only a couple of times.

Q. Have you worked with Mr. Treadon in the past?

A. No, ma'am.

Q. Have you worked with Mr. Ockerman or Mr. Schobert from Buckingham?

A. I've not worked with Mr. ockerman, I know Mr. Schobert. I don't think I've worked with him.

Q. I think we've gone through what is in your file.

Having had the opportunity to do a Common Pleas index in Summit County I find you are currently involved in one malpractice case; is that a fair statement, Doctor?

MR. TREADON: As a defendant?

Q. As a defendant. I'm sorry.

A. Yes.

Q. That was recently filed, June of 1999?

A. Yes.

Q. Burgess versus Dr. Oddi and this group.

Have you had an opportunity to give a deposition in that case yet?

A. No.

Q. I never can rely upon bureaucratically generated court reports. My search of the docket reveals you were not involved in any other cases; is that a fair statement?

A. Yes.

Q. Doctor, how much time have you spent reviewing the medical records, the films and anything else you might feel is pertinent in this case to arrive at the opinion you are going to tell me about today?

A. Somewhere between nine and 10 hours.

Q. what is your hourly charge for medical/legal records review?

A. $250.

Q. That's what you will be charging me today for deposition time?

A. Deposition time is $350.

Q. Do you know any of the doctors involved in this case?

A. As I was telling Mr. Treadon earlier in this case the only ones I know are Dr. Menia, who is the emergency medicine physician involved in Mrs. spreadbury's care, specifically because he was a resident at Akron General years ago. I know Dr. Chryssos by reputation, that's all.

Q. You have not had any professional interaction with Dr. Chryssos, you just know his reputation, that's it?

A. That's correct.

Q. Have you had the chance to speak with Dr. Menia?

A. No.

Q. Do you know where he is now?

A. No.

Q. I don't have any documents to help me but I'm going to rely upon your memory. when you were initially contacted by Mr. Treadon what were you told to evaluate in this case?

A. Whether or not there was a departure from the standard of care relating to the case in a patient who

turned out to have a traumatic rupture of the aorta.

Q. Have you evaluated this case from the point of view of standard of care as to the cardiothoracic surgeons only?

A. That is where my expertise lies, that's my focus, yes.

Q. Do you plan to offer opinion testimony only as to the cardiothoracic surgeons, whether or not they met the standard of care?

A. Yes.

Q. Will you be offering any opinions as to whether or not the radiologist met the standard of care?

A. No.

Q. Other than the gentleman who you've been retained to represent and the radiologist, as you reviewed this set of medical records did you make a determination that anyone other than these two groups of doctors deviated from the accepted standard of medical care?

A. Can you repeat the question, please?

Q. As you had the opportunity to read these records, aside from your assignment to determine whether or not the thoracic surgeons were within the standard, did you determine that any other doctors had deviated from the standard of care, or was that not anything you analyzed?

A. Do I read in your question there is a presumption

that the thoracic surgeon deviated from the standard of care?

Q. No. That may be my contention, all I want to know is are you going to offer opinions as to any of the doctors, Dr. Telesz, Dr. Menia, Dr. Sos, Dr. Packer, as to whether or not they met the standards of care?

MR. TREADON: I can represent to you I don't intend to ask him that question.

Q. I appreciate that. As you went through the record did you as a surgeon determine that anyone had deviated from the standard of care in the failure to discover this transection prior to the time of surgery?

A. No.

Q. That's what the question was. Sometimes I don't ask questions very straightforward.

In contemplation of today's deposition, have you completed any literature review?

A. I did search for a few papers concerning the treatment of traumatic rupture of the aorta, sure, I mean anybody would.

Q. How did you search that, MEDLINE or what did you use?

A. I just went to the medical library, asked them to do that. I presume they used MEDLINE or Grateful Med or one of those services.

Q. As a result of the request you made did the library return to your attention a list of articles dealing with the subject matter?

A. Yes.

Q. I request that Mr. Treadon provide me with the printout of the MEDLINE search and the articles contained therein.

A. okay.

Q. Subsequent to the time the library gave you the MEDLINE search and articles, did you pull the articles to read them?

A. The ones that I thought were pertinent, yes.

Q. Are you relying upon those articles in terms of rendering opinion testimony in this case?

A. Not entirely. They are additional information.

Q. Have you shared with Mr. Treadon those articles which you will be in part relying upon?

A. No.

Q. Let's go through your background and training that led you to your current profession.

I see that you went to Ohio state University, correct?

A. Yes.

Q. Got your degree in medicine in 1972?

A. Yes.

Q. You then did an internship for one year at Walter Reed?

A. Yes.

Q. In general surgery ■ take it?

A. Yes.

Q. '73 to '77 you completed a four year program in general surgery at Walter Reed also?

A. Yes.

Q. Then you do a two year residency at Brooke Army Medical Center?

A. Yes.

Q. cardiothoracic?

A. Yes.

Q. I always hate to sound uninformed, this time ■ am, where is Brooke Army Medical center?

A. Fort Sam Houston, San Antonio, Texas.

Q. Is it affiliated with another medical entity or is this the name of the entity?

A. That is the name, There is actually an E on it, B-r-o-o-k-e.

Q. Misspelled on your CV?

A. Yes.

Q. Subsequent to that I take it you did not participate in a cardiothoracic Fellowship?

A. Residency and Fellowship in cardiothoracic is

pretty much the same thing regardless of what people call it. For an actual Fellowship I'm told you are not supposed to be involved in daily care of patients, it's mostly a consultative program. In cardiothoracic residency we are involved basically 24 hours a day for two years.

Q. Subsequent to completing that residency, you then became certified in thoracic surgery?

A. Yes.

Q. I'm going to guess you passed your Boards the first time you took them?

A. Yes, ma'am.

Q. That was in 1980 when you became certified in thoracic?

A. Yes.

Q. You had actually become certified in general surgery in 1978?

A. Yes.

Q. As part of your thoracic surgery training, were you taught how to read CAT scans to look for injuries in the chest?

A. Everyone who goes through residency learns how to approach radiology interpretation of specific x-ray studies that are germane to that particular specialty. I don't consider myself an expert in radiographic

interpretation but I have some experience in knowing what to look for in particular studies.

Q. Does that include CAT scans?

A. Yes, although I will say that the CAT scans that we used to read in the 1970's are a poor distant cousin to the ones we have available now.

Q. Since the time you learned to read them, have you taken it upon yourself to become conversant with the newer CT technology so you as a thoracic surgeon could look at the CAT scan and potentially discern injuries in the chest?

A. with the understanding I always look at one with a radiologist because I miss things sometimes he'll point out, say this is such and such. You need to consider the three dimensional structure, what this is going to look like even though we have a two dimensional x-ray to look at. I would never base any kind of clinical decision on my interpretation alone.

Q. Have you had an occasion in the time that you've been a thoracic surgeon to look at the CAT scan, disagree with what the radiologist found in that?

A. No, I can't say that I have.

Q. when you completed your training at Brooke Army Medical Center, was your first place of employment here in Akron, Ohio?

A. No, I was in the military for four years beyond that, I spent three years in West Germany, at Landstuhl, L-a-n-d-s-t-u-h-1,West Germany, initially as assistant chief of thoracic surgery, then the chief for two years.

From there I was at Letterman Army Medical Center at the Presidio in San Francisco for one year. During that year I decided to leave active duty, search for a clinical practice.

Since I'm from Columbus initially I was looking for some place in Ohio. At the time the two surgeons in this group were looking for another to join them. We hooked up at a surgery meeting in January, '83. Then I ended up coming to Akron.

Q. You didn't put your military experience in there, I'm sorry, it didn't have a year, I made a presumption.

In 1983 you came here to Akron and joined -- was it at that time cardiothoracic and Vascular Surgery of Akron, Inc.?

A. Yes.

Q. It remained the same from 1983 through present?

A. Yes.

Q. Dr. Oddi, have you been insured with Mutual Assurance of Alabama at any time?

A. No.

Q. Subsequent to the demise of [redacted] who I know was

your carrier at least through 1996, who did you become insured with?

A. I have to check with the office manager to find out. I really don't know.

Q. Are you fairly certain it's not Medical Assurance of Alabama?

A. Am I absolutely certain, no.

Q. I ask you to extend the courtesy to me to advise Mr. Treadon who your carrier has been since the liquidation of PIE.

You came here in the 1983, tell me what you do.

A. I do cardiothoracic, peripheral vascular surgery that involves doing coronary bypass surgery, valve repair and replacement surgery. We used to do a fair number of pacemakers, the cardiologists do that now. We do a lot of pulmonary surgery for lung cancers, do esophageal surgery for esophageal carcinoma. A lot of the perivascular surgery for arterial plaque involving the carotid artery, abdominal aorta and its branches and lower extremity arteries, as well as I have a part to play in the residency program, general surgery in terms of teaching the residents both peri-operative management of cases as well as hands-on instruction in the operating room, and we also have students from the

Northeastern Ohio Universities College of Medicine rotate through the service on a regular basis. So, we have teaching responsibilities as well as our own clinical practice.

Q. Let me clarify this: Based upon my understanding from the past there is no thoracic residency program at Akron General; is that a fair statement?

A. That's correct.

Q. It's a general surgery residency?

A. Yes.

Q. You don't teach didactically in the classroom, you teach clinically; am I correct in that statement?

A. Yes.

Q. You are instructing students in general surgery?

A. We instruct general surgery residents in thoracic surgical problems, yes.

Q. At no time has there been an AMA certified thoracic surgery program at Akron General; am I stating that correctly?

A. Yes.

Q. Did you know Dr. Cawthon from NEOUCOM?

A. No.

Q. Do you teach on site in the classroom at NEOUCOM?

A. No.

Q. Are you a participant with the NEOUCOM students as

they are rotating through the hospital?

A. Yes, ma'am.

Q. Doctor, do you have an ATLS certification?

A. Yes, I do.

Q. When did you obtain that certification?

A. November, 1998.

Q. Prior to that time you had not endeavored to obtain that certification?

A. That's correct.

Q. what made you decide to get the ATLS certification? I'm asking if you know.

A. I just thought it would be wise to do that since we deal with a fair number of trauma patients. As of right now I'm trying to convince my partners it would be a good idea also.

The surgeon who runs the program at Akron General suggested to me about a year or so ago it would be wise to think about that. I had a good time taking the course, did well, plan to do it again in a couple of years,

Q. That certification and recertification for the same is available approximately every two years after you obtain it; is that fair?

A. Two or three years, I think it's three years actually.

Q. Did you save your materials from the ATLS certification course?

A. Did I save them?

Q. Yes.

A. You mean the manual? Absolutely.

Q. Have you had an opportunity to review that manual?

A. Since last November, no, I have not.

Q. would you consider that the information which is contained in the ATLS manual is -- first we will use the word authoritative in terms of its references on how a person should be treated for a blunt chest trauma?

A. The ATLS course has been devised and developed by the American College of Surgeons committee on trauma since sometime in the 1980's, I think most people, most surgeons would recognize that these are fairly good guidelines to work with, although really just like anything else it depends on your experience, the ancillary services you have available at your particular hospital or trauma center, They serve as good guidelines, yes.

Q. Fair enough, thank you for that answer.

Do you have an ACLS certification also?

A. Not current.

Q. when was the last time you were current with your ACLS?

A. 1982.

Q. As I understood what you told me, clearly I didn't give you a lot of time to describe your practice, what is your practice's relationship to the hospital in terms of being called in to evaluate trauma cases?

A. We have a rotating call schedule my four partners and ■, whoever is on call for our service on a particular evening is also available for trauma cases related to our specialty.

Q. That specialty of course being traumatic injury to the heart or chest, correct?

A. Or peripheral arteries, yes.

Q. This question has been asked already a few times of different people involved in this case, about how many times in the past, for you I guess about 16 years, have you had the opportunity to be involved in a case where a person has presented to this facility with a transection of the descending thoracic aorta?

A. I think I have had four cases personally, probably assisted on one or two others.

Q. Now I'm going to ask you hopefully some short medical questions.

Let's start with the following: Doctor, I gather you've been asked to testify as to the standard of care regarding Dr. Tawil; that's a fair statement,

correct?

A. Yes.

Q. Can you state for me as concisely as possible whether or not you feel that Dr. Tawil complied with the accepted standard of medical care required of a thoracic surgeon in his evaluation of the chest trauma that occurred in Mrs. spreadbury?

A. Yes, I think he did.

Q. what is the basis of that opinion?

A. His initial evaluation of the patient as the case was presented to him by the emergency medicine physician and his review of the initial radiographic study, as well as his proceeding with a very timely bronchoscopy to rule out tracheal injury, obtaining an esophagograrn to rule out esophageal injury. Providing for fairly close daily follow-up while the patient was in the intensive care unit.

Q. Do you have reason to believe that I on behalf of my client am critical of anything that occurred after September 24, 1997?

Let me ask you the question a different way: Did you understand what the nature of my allegation of medical negligence was against Dr. Tawil before you began your endeavor to look through the chart?

MR. TREADON: I'm going to object as to what is in your mind, or your expert's minds. Go ahead, Doctor, answer that if you can.

A. Before I began to look through the medical records?

Q. Let me ask it a simpler way so there is no confusion about the fact I'm not asking you to know what I was thinking. Were you told prior to the time you read the records what the basic allegation of negligence was against Dr. Tawil?

A. You know, I don't recall any specific conversation, I would suppose that Mr. Treadon had asked me to review the medical record with the idea that Dr. Tawil had departed from the standard of care since that was the allegation, and give an opinion about that.

Q. You just had a generalized question put to you, you weren't told specifically what my allegation of negligence was?

A. That's correct.

Q. Let's go through this. I gather that since you've just testified to the same, that you've had an opportunity at least four times in your career to be involved in a surgery to a transected descending thoracic aorta?

A. Yes, ma'am.

Q. Of those four cases to the best of your recollection were you called to evaluate the person in an emergency room setting or did they become your patient only after the diagnosis was already known?

A. No, I was called in an emergency room, emergency medicine situation, that is the usual way things are done.

Q. Can you outline for me, to a reasonable degree of medical probability, what you believe constitutes the standard of care in evaluating a blunt chest trauma to exclude the existence of aortic injury step by step?

A. The first is to try to get some idea of mechanism of injury at the accident because that has a lot to do with what you can -- what you project the injuries might be. You usually obtain that either from the paramedics written record or from the paramedic personally if you happen to arrive when he is still there.

Cursory physical examination involving the so called ABCs of ATLS management. By the time we get to the emergency room the emergency medicine residents have already done that.

Q. So that there is no mistake, when you say cursory exam, ABCs meaning airway, breathing, circulation, by the time you get there A and B are taken care of, usually the airway and breathing hopefully?

A. By the time we get there everything is taken care of pretty much.

Q. The C of ACLS is circulation, you are doing the physical examination to test or determine whether the circulation is intact, or explain it a different way?

A. To try to determine whether the patient's circulation is adequate.

In other words, you obviously depend on blood flow for brain function, kidney function, liver function, everything else, so unless there is adequate blood pressure, unless you can demonstrate there is some satisfactory measure of internal perfusion, usually on the basis of adequate urine output, you presume if the kidneys are getting perfused all the other internal organs are, and until you determine that you can't determine adequate circulation.

You palpate for the peripheral pulses in terms of strength and the pulse rate, how the extremities look. In terms of whether or not they are pink or cool or warm, kind of a general physical. This entire thing of the ABCs shouldn't take more than a couple minutes initially. By the time we get there it is pretty much done, at least some initial observation recorded in the chart.

Q. The question was, I wanted you to state for me as

comprehensively as possible what the standard of care requires to test for the existence of an injury to the aorta in a blunt chest trauma, I've got a feeling it goes beyond this.

A. Yes. The next thing obviously is to do -- once you determine that the patient has an adequate blood pressure, is fairly stable, you want to do a kind of secondary assessment in which you palpate the chest wall itself to look for any rib fractures, any evidence of ecchymosis or bruising in the skin and subcutaneous tissues.

If the patient is awake you want to know whether or not they grimace with pain when you touch certain areas, you push on ribs or the sternum. Want to look for any evidence of break in the skin that might be of concern in terms of possible penetrating injury. Then you get a kind of expeditious chest x-ray to look for any evidence of rib fractures, pneumothorax with a collapsed lung, what they call soft tissue masses which may be evidence of severe bruising within the muscles, underneath the skin. Look at the cardiac shadows, look at the lung fields, then go from there.

Q. Let me stop you where we are. My question related to how do you test to determine that there has not been or is the existence of an injury to the aorta, what

relationship do rib fractures have in making the preliminary assessment that would allow you to have a degree of suspicion about an aortic injury, or are they not relevant in your opinion?

A. They certainly are relevant. Basically in somebody who is fairly young, otherwise healthy, it takes a fair impact to break a number of ribs. older people have brittle ribs, they break easily. I've had a patients who fell off of a two step ladder, have multiple rib fractures in their 70's and 80's. You can't match much about the degree of impact, but in someone who is young and healthy it takes a fair amount of impact. If somebody has multiple fractured ribs, they have taken a pretty good shot in the chest wall.

Q. In your set of records you don't have any prior medical records from Miss spreadbury, do you?

A. No, ma'am.

Q. Based upon your complete and thorough evaluation of this chart would you characterize Marla spreadbury as a person who presented to the hospital as young and otherwise healthy, except for the accident she had just been involved in?

A. That was my impression. she had two or three back operations in the past by the record, I didn't see any evidence of any overwhelming medical problems, no.

Q. Do you have a recollection of the number of ribs that were fractured in this patient?

A. After the dust settled there was more than the initial x-rays, there were eight ribs on the left, three or four on the right.

Q. Based upon your review of the literature, your training, your experience and your recent completion of the ATLS course and certification, what particular significance is there to rib number 1 and 2 being fractured in this kind of setting?

A. Any time you have the first rib, especially the first rib fractured, that requires a pretty powerful injury, you have to think about the possibility of a major vascular injury, whether that involves the aorta or one of the other large vessels in the chest.

Q. What other large vessels would you be looking to be injured other than the aorta in this kind of impact?

A. You would look for the left common, left subclavian artery, any intercostal arteries that are in proximity to those ribs that are fractured.

Q. As a matter of academic curiosity, not to be surprised at trial, based on your review of the records, did you find evidence there was injury to any of the other major arteries in addition to the aorta?

A. No.

Q. So we're back to -- we've established you get a chest x-ray, then what on a chest x-ray would you be looking for that would cause you to do further exploration as to whether or not there is an injury to the great vessels?

A. significant pleural fluid accumulation, more commonly on the left than right, can be bilateral.

Q. Why is it more common on the left?

A. Because that is where the descending aorta is. I'm not sure why it is, statistically it is.

Q. If you -- I'm sorry. Go ahead.

A. That's okay.

Again rib fractures, that is a prominent sign, especially the first and second ribs as you point out.

What is called a widened mediastinum is also significant.

In terms of major vascular injury inside the chest from blunt trauma we can talk about right deviation of the trachea, simply because when the aorta gets injured, the associated hematoma will commonly make the trachea deviate to the right.

It can also lower the left main stem bronchus so the angle between the trachea and bronchus is increased.

If you have an NG tube or nasogastric tube down the patient to decompress the stomach, that very commonly will be deviated toward the right for the same reason the trachea is.

There is also talk about pleural or apical capping in the pleural space, that relates to blood accumulation or hematoma in the apex of the pleural space that is thought to be associated with major vascular injury. I can't think of any others right now.

Q. In terms of having your level of suspicion increased based upon these findings, did you need to have any or all of the associated findings for that suspicion to be established?

A. I think any time you have one of them in the appropriate setting you have to think about it. Basically if you've had much experience with chest trauma at all, there is a little light bulb that goes off inside your brain when you see something like that.

Q. That bulb meaning possible injury to the aorta, that's the light bulb?

A. Possible major vascular injury inside the chest.

Q. How many of these factors from review of the records did Mrs. spreadbury have?

A. She had bilateral pleural fluid, she had the

obvious rib fractures, she had what was thought to be widening of the mediastinum. I don't recall whether she had a nasogastric tube in when she had the initial chest x-ray or not, I can't remember.

Q. Have you recently reviewed the chest films?

A. No, not recently.

Q. Do you have a recollection, I know you didn't keep any notes, from initially looking at them in June or July did you make notes what the findings were on the chest films?

A. No, because I knew I would take a look at them again sometime.

Q. Do you know if you detected a deviation after the NG tube was placed?

A. No.

Q. So at this point we have a chest x-ray, it has the pleural effusion and rib fractures, a widened mediastinum; do you agree with that?

Thought to be widened in at least one chest film, or the CT there was a distinct margin of the mediastinum in the superior aspect?

A. Yes. while the quality of the portable chest x-rays are notoriously inadequate in terms of defining anything, the purpose for getting an emergency portable film is to look at the lung fields, make sure that the

lungs aren't collapsed, that you don't have the very gross displacement of the mediastinum, that is the only thing I can tell from the portable chest x-ray. The standard A/P portable chest film, especially in large patients, will almost always show a widened mediastinum, that in itself is pretty unreliable.

Q. So would you agree with this statement, since you are advocating the position it's necessary to take the portable A/P in trauma situations, that the mediastinum widened is not the be all, end all, if that is not there, there could still be a traumatic injury to the aorta?

A. Sure.

Q. So you obtained the chest work, then what is the next step in the situation like this to exclude the existence of an injury to the aorta after you have these findings on chest film?

A. Presuming the patient is stable enough to be transported we go to the CT scanner in the radiology department.

Q. The purpose of CT scanning is to screen for the existence of findings that are suggestive of injury to the aorta; am I stating that correctly?

A. There are a lot of people at this point in time who because of the fairly good definition you get on CT

scan will make a diagnosis on the basis of the scan alone. I'm not sure that is generally accepted, that is certainly written in the literature.

Q. Let me ask you the question and I will infuse a few things: In this case as you are aware, Dr. Tawil was advised by Dr. Cawthon there were not findings suggestive of an aortic injury on the CAT scan; do you know that from reading the testimony?

A. Yes.

Q. The fact there was an injury to the aorta, obviously you can concede that?

A. Yes.

Q. In this instance, when you have a situation where the chest film reveals pleural effusions, bilateral rib fractures, especially left 1 and 2, potentially indistinct margins or widened mediastinal findings, is it acceptable to rely upon the radiologist telling you that the CAT scan is negative, doing nothing further?

A. Depends on the radiologist. If it [redacted] a radiologist I've worked with for the last 10, 15 years like there are at Akron General, [redacted] have implicit faith in their interpretation, yes.

Q. Let me see if I understand your answer. Did you just qualify your answer to say if you as the thoracic surgeon had absolute faith in the radiologist you could

then rely upon their interpretation of the CT?

A. Yes.

Q. If you didn't have absolute faith, but you had the previous chest film findings we discussed, given the high potential for injury do you proceed to another form of testing?

A. If you presume that someone is a Board certified radiologist, knows what he or she is talking about, given the fact that there is no invasive test that I know of that is without the potential for complications, the radiologist tells me there is no evidence of a great vessel injury, I'm not sure exactly whether I would rush the patient over to the aortography suite at that point or not, probably would not.

Q. why?

A. Because of the potential for complications of arteriogram.

Q. Where is the potential for injury greater, the injury potentially from the aortogram in terms of the percentage, or dying from an undiagnosed transected descending thoracic aorta if it is in existence?

MR. TREADON: objection. You may answer.

A. The answer to that is the obvious. We're looking at things retrospectively.

Q. Yes, we are.

A. Let me ask you this.

Q. I'll see if I can answer the question for you.

A. It's an honest question. If I'm a trauma surgeon, patients are involved in blunt chest injury with motor vehicle accident, does every patient that comes in the hospital who has a suggestion of widened mediastinum whose been involved in an automobile accident get an aortogram? The answer to that is no, simply because there overkill there, you are going to be doing a lot of unnecessary aortograms,

Q. When you said the answer is obvious, there is a greater risk in terms of mortality to the patient in not discovering the transection than there is a risk of aortography?

A. Yes.

Q. what do you believe that ATLS says you should do in a situation where you have a person whose got documented pleural effusion, rib fracture of 1 and 2 on the left, potentially a widened mediastinum, if you get a negative CAT scan?

A. Again, I haven't reviewed that recently, I think that given the clinical situation, from what you tell me, the CAT scan has no evidence of any great vessel injury, at least according to the interpretation of the

experienced radiologist, I would probably watch that patient overnight, see what happens in the next six to eight hours.

Q. You as the trauma surgeon -- I mean the thoracic surgeon --

A. As the thoracic consultant.

Q. -- you would be watching them.

In this case, do you have an opinion -- you looked at the CAT scan; is that right?

A. Yes, ma'am.

Q. Are you, Doctor, competent -- I got in trouble with Mr. Treadon for using that word -- are you able as the thoracic surgeon, based upon your training, to look at the thoracic CAT scan and discover those signs and symptoms which may suggest a tear in the aorta?

A. I think I am. I'm not a radiologist, there are certainly subtle things I miss. Anyone who claims that he is able to interpret x-ray studies better than a radiologist, I would have to question his own voracity.

Q. [redacted] it apparent to you, can you concede there are some people who are involved in the teaching and training of residents in a thoracic program who might have an opportunity to look at CAT scans on a daily basis such that they could increase their expertise as a thoracic surgeon and the ability to see those findings?

A. Sure.

Q. Were you able to see any finding on the CAT scans that were suspicious for injury to the aorta?

A. Yes.

Q. I'll ask a question for someone else that might ask it.

Were you able to find those because they were pointed out to you?

A. Yes.

Q. Independent of them being -- what happened first, did you look at it and didn't see it and then someone pointed it out, said how about that?

A. I had a question.

Q. what question did you have, Doctor?

A. There was slight irregularity of the aortic contour on one of the slices, there was a kind of a radiolucent line on one of the other slices that suggested perhaps an intimal tear.

Q. You saw something that perhaps suggested intimal tear, I'm working backwards, you also saw something where the contour was slightly -- did you use the word distorted?

A. Distorted or irregular.

Q. The aortic arch area?

A. Or perhaps just beyond the aortic arch.

Q. You would call that technically what, that change or that finding?

A. It could be suggestive of an aortic injury, could be remanent of a vascular ring that I have seen pictures of in the past. Again, depending on the position, degree of rotation of the patient, it may or may not be significant.

Q. Doctor, if a radiologist who you are relying upon to include or exclude -- I'm not sure which is the best way to phrase it -- an injury to the aortic area, the descending aorta, decides there were troubling findings, did additional thin cuts, would you expect to be told that as a thoracic surgeon?

A. No.

Q. You wait and see what their interpretation was?

A. They do that all the time, the radiologist will say I'm not sure about this one area, we will get a few additional cuts, they don't call me, ask my opinion about that, that is their area of expertise. If they feel additional views are necessary, I would certainly never argue with that at all.

Q. I didn't ask the question very well.

The question I asked you is you are the thoracic surgeon, you're awaiting diagnostic information that will help you to determine whether or not a person

has an injury to their descending thoracic aorta, would you want to know personally to make future diagnostic decisions or treatment decisions that the radiologist was having difficulty interpreting the results in a certain area of the mediastinum?

A. I think I would.

Q. Knowing that, how would that factor into your decision to do something, if anything, further?

A. I would want to have a personal conversation with a radiologist, maybe have another opinion.

Q. Another opinion from another radiologist?

A. Yes.

Q. Mr. Treadon gets mad at me when I ask something that as been answered, I like to make sure I heard it. To be perfectly clear, when you looked at the CAT scan for the first time without someone pointing it out to you, you had questions?

A. Yes. Can I add something there?

Q. Absolutely you can.

(Discussion had off the record.)

A. I don't whisper very well.

Q. At least you are trying to be straight forward, that's okay.

A. Let me say after having looked at the x-rays --

Q. The chest x-rays?

A. No, the CT scan.

Q. I don't want to be confused.

A. I took that entire study, put it up on the large viewbox in the radiology department at Akron General, had one of our what I think is very experienced radiologists who reads a lot of CT scans take a look at it. Basically what that radiologist said is oh, there is a lot of subcutaneous air I would be worried about.

I told the radiologist this was a case from a couple of years ago, the patient had been in an auto accident, she said there is a lot of subcu air, I would be concerned about possible tracheal injury. There is a lot of fluid in both pleural spaces, I wonder what that means.

I said do you see anything else. The radiologist said no. I pointed out those two slices on this study, the radiologist said you know, I was focusing on this other stuff, that totally slipped by me.

We do that clinically all the time, we focus on a particular problem, may miss some other things. clinicians do that, radiologists do that, dermatologists do that. You focus in on one area that

is very obviously abnormal, you may miss something. It happens.

Q. I appreciate it, I really do, you relating to me candidly what you did in an endeavor to understand this case, to reach conclusions.

I want to go back to my first question. You found something on the films on your own without the assistance of a radiologist first?

A. Yes.

Q. That's what I needed, Doctor.

A. Can I do that again if somebody gave me a study, maybe, maybe not.

Q. I think it's clear from your testimony today customarily you attempt to work with a radiologist whose experience level you know, you can rely upon their CT results; am I restating that fairly?

A. Yes.

Q. Do you think that Dr. Tawil should have seen the same suspicious areas that you saw?

A. That's pure speculation on my part.

Q. Did you understand from his deposition testimony where he was trained?

A. Yes.

Q. Are you familiar with Dr. Gahaus' cardiothoracic program at University Hospitals?

A. Not specifically. I know that he came from Yale University with an excellent reputation, basically international reputation. I can't imagine he doesn't run a top notch program.

Q. Dr. Gahaus?

A. Dr. Gahaus.

Q. Can you tell me, do you know what Dr. Gahaus' approach is in training in CAT scan in the cardiothoracic program?

A. No, I don't.

Q. When you took your recertification and for the Boards in 1990, do you have a recollection of having your mettle tested as it were, your ability to look at a CAT scan and interpret it; do you recall questions in that area?

A. I don't recall specific questions. This is basically you submit an application, including 100 consecutive cases, surgical cases you've done, the Board sends you what amounts to being an open book test. I'm certain there were some radiologic studies on some of these questions, I don't recall specifics about that.

Q. Fair enough answer.

I don't usually do this, I really need the glass of water, I'm on antihistamines, can we take a one minute break for me to find a glass of water.

(Recess had.)

BY MISS KOLIS:

Q. Doctor, we've gone through what you think the standard of care requires, to recapitulate. Essentially we were at the phase where you get a CAT scan, if the CAT scan has any questionable inference that you then need to make a decision to go to surgery or aortography; that's a fair statement?

A. About whether to go to the aortograph or observe the patient for the next several hours.

Q. Sorry, I did misstate that.

Can you outline for me so I don't miss this, what findings in a CAT scan you would find to be suspicious for or suggestive or consistent with an aortic injury?

A. Any irregularity of the aortic contour that I couldn't ascribe to obvious atheromatous disease in older patients, an extravasation or escape of the contrast from the aorta to surrounding tissues. Any what is called a wedge-shaped defect in the aortic wall. Basically anything that didn't look completely smooth, unless it could be ascribe to atheromatous disease, would be reason for suspicion.

Q. what about a mediastinal hematoma?

A. You see mediastinal hematoma in chest trauma all the time. If the aortic contour is completely smooth I would say probably due to ruptured mediastinal veins or one or two little intercostal arteries. The mediastinum is filled with blood vessels. If the aorta looks otherwise good, I'm not sure I would make too much of the mediastinal hematoma in and of itself.

Q. Let's skip to your options. One of your options when you find things from the screening CAT scan that aren't exactly regular, or they are suspicious, is to do an aortogram or watch the patient, correct, that is what you just testified to?

A. Right, depending on the clinical situation, although I think if there were any suspicious findings on CT scan I would probably recommend an aortogram to be on the safe side.

Q. What would you be watching the patient for?

A. Any kind of clinical instability, drops in blood pressure, drops in hematocrit or blood count, anything suggesting hypovolemia, which basically is a decrease in blood pressure, increase in heart rate. Any increasing respiratory difficulty that the patient might have, although this patient is paralyzed, on the ventilator, you couldn't really --

Q. You can't judge that because of her being mechanically assisted and supposed1y maintained at a certain 1evel?

A. Yes.

Q. Did you from the chart notice any changes in the evening in Mrs. Spreadbury's respiratory status that would have concerned you as a thoracic surgeon?

A. I can't recall any changes in respiratory status.

Q. Is that something you would have made note of in terms of reviewing this chart?

A. I certainly should have, I don't recall anything specific.

MR. TREADON: You don't have to do this by memory if you want to look.

Q. If you want to look if there is anything in that evening that bothers you.

A. The only note in the physician's progress notes is from Dr. Telesz at 6:00 p.m. that relates to very transient decrease in blood pressure that responded fairly adequately as far as I can tell to some increase in I.V. fluid administration.

Let me take a quick look at the nursing notes.

Q. That's fine, Dr. Oddi, we are doing good, we're only at the one hour mark.

A. It's a sad thing to say, very commonly the nurse's are --

Q. Better than doctors' notes?

A. More informative and much more legible than the doctors' notes, that's true. The nurses' notes state that right around 5:15 p.m. the patient was fairly combative to Dr. Tawil's attempt to do the bronchoscopy at that time.

Q. what significance does that have to you; if any, in context of ongoing watchfulness for potential aortic injury?

A. Theoretically anybody who exhibits increased anxiety or respiratory difficulty could be having some bleeding inside the chest. If you are trying to put a bronchoscopy in somebody's mouth, it's hard to sort all that stuff out, it depends on what else is going on. I'm not sure I make too much of that of itself. I don't really see anything else.

Q. I just wanted to ask that question. Let's skip to a different issue.

Doctor, I suspect highly the answer to the following question is yes: Are you going to be rendering an opinion at trial as to the cause of the paraplegia in this patient?

A. Yes.

Q. why don't you briefly in the initial phase tell me what your opinion is?

A. It's a terrible thing to admit, but if you read the medical literature, there are a certain percentage of patients who have successful thoracic aortic rupture repair operations, the surgeon is pleased with the result after the operation being able to repair or replace that part of the aorta that is injured, then you have the patient wake up not being able to move his or her legs. That is about as depressing as anything.

The fact of the matter is because of the variability in blood supply to the spinal cord and the fact that it's necessary to clamp off a fairly good portion of the thoracic aorta to do this operation, anyw e f . depending on the study that you read, 3 to 20 percent of patients will be paraplegic after these operations.

Q. Anything else you would like to add to that?

A. In terms of?

Q. Probably didn't ask the question the best way, let me put words in your mouth, we will digress from there.

MR. TREADON: she asked you the cause of paraplegia.

Q. I'm asking you your opinion as to the cause of the paraplegia in this patient.

A. I think it had to do with clamping of the aorta, the spinal cord ischemia, when that happened.

Q. You've read Dr. Donahue's deposition as well as Kralik, Chryssos and Tawil?

A. Yes.

Q. Have you been made aware of the content of the testimony of Dr. John Anastasi taken last Friday?

A. Yes.

Q. Did anything that was related to you about Dr. Anastasi's testimony change your opinions in this case?

A. No.

Q So it's your opinion that the surgery itself is what caused the paraplegia?

A. Yes, ma'am.

Q. Let me ask you some foundational questions, we will go backwards to some testimony questions.

You've had the opportunity to do four repairs, what is your preferred method if you have one for repairing a transection of an aorta?

A. classically and I'm sure you know this from reviewing the literature, there are a few different ways to approach these cases.

Classically the way to do this was to use what some people call a clamp and sew technique.

You clamp the aorta, both above and proximal and distal to the injury, open the hematoma, see exactly what the situation is, primarily repair the aorta or replace that part with a prosthetic tube graft. Statistically or theoretically if this aorta clamp time is in the range of 30 minutes or less, then that is supposed to decrease, not eliminate the possibility of paraplegia in those patients. If it goes much beyond 30 minutes the probability of paraplegia increases with time.

The other ways to do this provide some type of shunting of blood flow to the lower extremities around the area that you are working on. There are a couple of different ways to do that.

One is Heparinized shunt to go around, the other is called a partial bypass with a Heparinized circuit so you don't have to give systemic Heparin, which you don't want to do in acute trauma eases.

My way of doing this in the past was to clamp and sew. If I had a case come in tonight in a patient in whom I had the time to set it up, I would do what is called a left arterial to femoral bypass realizing that doesn't eliminate the possibility of paraplegia, it decreases it.

The reason I say that is because the contribution from the anterior spinal artery may be very

significant, from those intercostal branches of the aorta and part of the aorta that is being clamped off. In that case you may provide a good blood flow to the legs and kidneys, you may not provide a good blood flow to the spinal cord. In those patients they still may wake up paraplegic. It's theoretically a more reasonable thing to do to try to do whatever you can to try to minimize the chance of post-op paraplegia.

Q. Let me ask you a couple of questions about what you said.

When you say theoretically, I gather you don't make the transformation in your own practice from you call a cut and clamp, I've heard clamp and sew, we all understand what that means, your transformation to using a method of bypass, was it based on a theoretical lick and promise, or you felt there was an actual based on scientific principle of having a better chance of not becoming paraplegic to your patients; do you understand the question?

A. It's scientific principle.

Q. when you said it decreases the risk of paraplegia when you have the time to set it up, do you agree in this case based upon the presentation of the patient to the OR there was no possibility of using a bypass method on this patient?

A. Absolutely.

Q. Do you agree that if the transection had been discovered the day before, that more likely than not a bypass method could have been used to protect this person's spinal cord function?

MR. OCKERMAN: objection.

A. It depends on the particular surgeon. I don't know what Dr. chryssos and Kralik prefer to do. I have a personal friend do every one of these cases'with clamp and sew technique.

Q. They do it in less than 30 minutes?

A. Not always.

Q. My question was, which I would like an answer to, if the transection had been discovered on the 23rd, you would have to agree with me it was impossible to have done on this patient a bypass procedure at that time?

A. Yes, but the corollary to that is you are asking me whether or not that would have eliminated the paraplegia Mrs. Spreadbury suffered, that is pure speculation.

Q. I understand that may be your answer, we will work with that in a second.

Do you believe that Mrs. Spreadbury because of her hypotension -- first of all, when was her first serious episode of hypotension in this case?

A. From the medical record it was about 6:00 p.m. on the 23rd.

Q. That rebounded very quickly, didn't it?

A. To increase in I.V. fluids, yes.

Q. Her next episode -- do you remember what her pressure was at the episode you are talking about?

A. Dr. Telez recorded the pressure was 70 to 80 systolic.

Q. The next episode of hypotension that you can determine occurred when?

A. On the 24th at about 9:00 a.m.

Q. Am I correct in my memory that was 35 over -- I don't want to say 20, is it 20?

A. I don't recall the number.

Q. You want to look in the nursing notes to be sure?

A. *Yes.*

The recorded pressure at 9:10 a.m. on the 24th was 35 over 21 as recorded by arterial line, yes.

Q. What do you suppose caused Marla Spreadbury's pressure to record at 35 over 21 at 9:10 a.m. on the 24th of Septembe ?

A. You would have to presume there was acute volume loss, blood loss that occurred right at that time.

Q. What are the possible sources for the acute blood

loss at that time?

A. The most likely source is an acute expansion of the hematoma that she turned out to have secondary to the aortic injury.

Q. Let's talk about that concept.

Doctor, since you know I don't get to see you again until trial, I like to bug you now. Is there any medical evidence contained in the record or any other explanation for the blood pressure other than acute expansion of that hematoma?

A. If it's a reliable blood pressure reading, I don't see any obvious explanation for that

Q. When we say acute expansion, let's I guess work on that concept.

What do you think the progression of transection was from the time she was transected until the time she ruptured?

A. Typically a portion of the aortic wall will be torn by the blood flow, will be contained by surrounding tissue, typically the adventitia, which is the internal lining of the aorta and at least part of the media which is the muscle layer or middle layer is torn. The media and adventitia comprises about 60 percent of the architectural strength. As long as the adventitia is intact, theoretically the patient will be stable ce

that develops a tear in the adventitia such as the one containing the hematoma or what are called the mediastinal soft tissues and mediastinal pleura, that begins to expand very quickly, depending on the blood pressure.

Q. Let me ask you a surgery question.

would you agree that it would be preferable in a person who has a transection of their descending thoracic aorta to perform the surgery prior to the time that the collection of blood breaks through the adventitia?

A. Yes.

Q. This period of time where the blood pressure as I think you and I have now established at 9:10 is dropping due to acute expansion of hematoma, at that time is it a fair and accurate medical statement that if the hematoma is expanding outside the adventitia, now for sure less blood is going to the spinal cord?

A. No.

Q. You don't think that is an accurate statement?

A. I'm not sure why that would be the case.

Q. what causes spinal cord ischemia?

A. Decrease in blood flow through

that supply or arterial branches that contribute to the anterior spinal artery.

Q. The descending thoracic aorta supplies what arterial branches?

A. Again it's variable from one person to the next. Some of the intercostal arteries that originate under each rib can provide a contribution and the anterior spinal artery.

Q. As the hematoma is expanding outside the adventitia, starting to carrying and supply less of a blood supply to the branches, the blood is being rerouted outside of this area; do you agree with that?

A. It depends how much blood is getting lost.

Q. Do you believe that in this case her paraplegia was caused by a hematoma compressing upon the artery of Adamkiewicz?

A. No,

Q. Are you aware that was testified to as a potential cause by Dr. Kralik, I use the word potential, he said possible, he didn't say that was the cause.

A. I don't believe that.

Q. Do you recall that Dr. Chryssos testified that the surgery was not the cause of the paraplegia?

MR. TREADON: I'm not certain he did.

Q. We will make it easy, 1'71 go through this. Mr. Treadon is very good at following up statements that

I make.

First of all, you are aware that Dr. Tawil testified -- you read his deposition, correct?

A. Yes.

Q. -- he would be unable to determine the cause of the paraplegia; do you recall that?

A. No, but I can understand why you would say that.

Q. Actually let me restate, I don't want to be on the record with inaccurate statements.

Page 62, line 4 of Dr. Tawil's deposition he testified that there is no way he can tell when she was paraplegic, had you read that statement?

A. Yes.

Q. Given that you read that statement, you're indicating that you believe that the surgery is the cause of the paraplegia, correct?

A. Yes.

Q. So therefore she wouldn't have been paraplegic before the surgery?

A. Repeat that please.

Q. Therefore if it's your belief the surgery itself caused the paraplegia, she could not have been paraplegic prior to the surgery?

A. Yes.

Q. Have you read Dr. Tawil's admission and discharge summary in this case?

A. Yes.

Q. Are you aware that he listed in his discharge summary that Mrs. spreadbury suffered from pre and post-op paraplegia?

A. Yes, that was qualified in Dr. Kralik's deposition when he mentioned because she was at least partially sedated it was really impossible to do an adequate neurological exam on her pre-operatively. I'm not sure you can say somebody is paraplegic because they don't seem to move their toes to either command or painful stimuli if they are under sedation.

Q. If the person was under sedation to the extent sufficient enough to prevent them from moving their lower extremities, wouldn't that necessarily indicate they wouldn't be able to move the upper extremities?

A. Probably.

Q. Are you aware she was in fact moving her upper extremities on the morning prior to the surgery, not moving the lower extremities?

A. As I recall she was moving her toes but the degree of moment was not thought to be what would be expected on the basis of how well she was moving her upper extremities.

Q. Can you point to me a place in the record where you see an indication at any time after 9:10 in the morning of September 24th, testimony or records that she was moving her toes? I have time, I'm not worried about having to pay you.

MR. TREADON: You want him to look at all the depositions too?

MISS KOLIS: I want him to make sure that as part of forming his opinion is there testimony or any records that she was moving her toes at any time after 9:10.

MR. TREADON: That isn't what he said. I don't think what you said is what he said. You said after 9:10?

MISS KOLIS: Yes, after 9:10, that is what I'm looking for.

MR. TREADON: She was or was not?

MISS KOLIS: I thought if you want to run this back to save 15, 20 minutes, I thought that what the doctor said was, I asked the question about if a person was in a paralytic state due to medication, that was the reason for not moving their feet or toes, that you would expect they didn't have upper arm movement, he agreed with that. I asked if he was aware in the morning she had the ability to move her

upper extremities, the ability to move the lower extremities, he seem to have recalled there was some piece of information she was moving her toes in the morning.

MR. TREADON: In the morning, before 9 10 or after 9:10?

Q. Any time in the morning, once the doctor started writing narratives, I'm not talking --

MR. TREADON: Twelve o'clock midnight on the -- the morning is a long period of time.

Q. I want to know if at 9:10 she was moving her toes?

MR. TREADON: That's a different question.

A. There is nothing in the physicians' or nurses' notes about that. My recollection was that Dr. Kralik mentioned he had been in to see the patient that morning when he was called after she dropped her blood pressure, I thought he mentioned that she was moving her toes, I may be mistaken. I would have to go through his deposition again.

Q. I'll accept that. I assume you probably will go through his deposition again.

A. Yes, ma'am.

Q. From reading Dr. Kralik's deposition do you have a recollection of the fact that I asked him for his

opinion as to when Mrs. Spreadbury became paraplegic?

A. I'm sure you asked that question, I can't remember his exact response.

Q. Do you recall, Doctor, that in sum total after pages of his deposition, that he did not at all indicate the possibility of surgery being the cause of the paraplegia in this case?

A. No, I don't remember that.

Q. Dr. Chryssos, do you remember what he thought the cause of the paraplegia was?

A. I think he mentioned that because the patient was severely hypotensive in the early part of the operation, also there was some increased difficulty of the procedure because of the mild anomaly she had in her aortic arch, it made the operation a bit more difficult than otherwise, he thought that contributed to it, because basically the patient was without a blood pressure I guess for several minutes,

You know, to be honest with you, as I review the record and operative note, a few journal articles, Mrs. Spreadbury had a very significant likelihood of not surviving the operation. I think it's kind of a testimonial to the surgical expertise of Dr. Kralik and Dr. Chryssos she is even alive at this point.

Q. You do understand I've not personally sued them or accused them of medical negligence?

A. Yes.

Q. Do you recall when I specifically asked Dr. Chryssos if he felt the surgery was the cause of paraplegia, he said no?

A. Again, I would have to go back and take a look at his deposition. If you say that is what he said, I'm sure that is what he said.

Q. Let me ask you something else, I don't know how much it has to do with any of the issues in this case, I become more curious as the days go by.

Marla spreadbury apparently had a two vessel aortic arch, that was a finding on aortography; did you see the aortogram?

A" No.

Q. I gather what I heard you say, I restudied the literature because of something Dr. chryssos said, how does a two vessel arch such as described in the aortogram -- if you would like to see it I highlighted it to make it easier -- effect the surgery in this case?

A. I'm just kind of trying to read his mind. As far as I can tell it makes the decision where you can safely put the clamp proximal to the subclavian artery a bit problematic.

Q. I wasn't asking you to read his mind. I'm asking you a medical question based on your training and experience as a thoracic surgeon, how would this effect the surgery. You are telling me it comes into play where you are going to place the clamp, correct?

A. Yes.

Q. Did you discern from reading the deposition or reading the operative summary that the clamp was placed in the wrong position because of this anomalous anatomy?

A. It was described by Dr. chryssos, yes.

Q. What do you think lengthened this surgery to 45 minutes, the extent of the double vessel arch or the fact when Dr. Kralik opened her chest, it was full of blood?

A. Both.

MISS KOLIS: I'm going to step out in the hallway with Melissa.

(Recess had.)

MISS KOLIS: I'm not going to ask you any further questions unless Mr. Ockerman has something that causes me to think of another question.

CROSS-EXAMINATION

BY MR. OCKERMAN:

Q. Doctor, so I can get the sequence correct, you had the records prior to reviewing any x-rays; is that correct?

A. Yes.

Q. So you had a chance to review the records?

A. I had the medical records before the x-rays.

MR. OCKERMAN: No further questions. Thank you.

MISS KOLIS: I don't have any questions. Are you going to have your doctor read?

MR. TREADON: He's not my doctor. You have the right to read the transcript to make sure what was taken down accurately reflects what you said here today. I recommend that do you that.

MISS KOLIS: I'll waive the seven day reading requirement with the standard promise within 30 days.

MR. TREADON: You can send it directly to the doctor.

(Deposition concluded; signature not waived.)

ERRATA SHEET

NOTATION	PAGE/LINE

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

_____

MICHAEL ODDI, M.D.

The State of Ohio,

County of Cuyahoga. : CERTIFICATE:

I, Constance campbell, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, MICHAEL ODDI, M.D. was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 22nd day of October, 1999.

Constance Campbell, stenographic Reporter,

Notary Public/State of Ohio.

Commission expiration: January 14, 2003.

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ERRATA SHEET

NOTATION	PAGE/LINE
DONAHOO	8/5,6
blush → blurb	11/9
perivascular → peripheral vascular	23/19
the ~~innominate~~ innominate, ⓒ common carotid, ⓔ Subclavian	34/18
distinct → indistinct	37/20
"chest work"?	38/14
whose → who's	41/8 & 18
voracity → veracity	42/19
DR GEHAUS' → DR GEHA'S	47/24
DR. Gehaus → DR. Geha	48/5 & 6
to go to dortography	49/11
bronchoscopy → bronchoscope	52/15
"Lick and promise"?	56/16
impossible → possible	57/15
internal → external	59/20
the media Laventitis → the adventitia	59/22-7
moment → movement	63/23

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

MICHAEL ODDI, M.D.

The State of Ohio, :

County of Cuyahoga. : **CERTIBICATE:**

I, Constance Campbell, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, MICHAEL ODDI, M.D. was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

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Constance Campbell, Stenographic Reporter,
Notary Public/State of Ohio.
Commission expiration: January 14, 2003.

Curriculum Vitae

MICHAEL A. ODDI, M.D

ADDRESS:

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(330) 665-5008

PERSONAL DATA:

Born: 10-16-47
Wife: Rebecca

EDUCATION:

Ohio State University College of Medicine
BA 1968

Ohio *State* University College of Medicine
MD 1972

Internship 1972-1973
Walter Reed Army Medical Center
Surgery

Residency 1973-1977
Walter Reed **Army** Medical Center
General Surgery

Residency 1977-1979
Brook Army Medical Center
Cardiothoracic Surgery

BUSINESS LOCATION:

Cardiothoracic & Vascular Surgery of Akron, Inc
224 W. Exchange St., Suite #300
Akron, Ohio **44302**
(330) 762-9163

CURRENT APPOINTMENTS:

Clinical Assistant Professor
Northeastern Ohio College of Medicine

LICENSE:

35029 Ohio

PROFESSIONAL ORGANIZATIONS:

American Board of Surgery
Board certified 1978

American Board of Thoracic Surgery
Board Certified 1980 Recertified 1990

PLAINTIFF'S EXHIBIT
A 10-18-99

Curriculum Vitae

MICHAEL A. ODDI, M.D.

PRINCIPAL HOSPITAL:

Akron General Medical Center
400 Wabash Avenue
Akron, Ohio **44307**

MEMBERSHIPS:

American College of Cardiology
American College of Chest Physicians
American College of **Surgeons**
American **Heart Association**
American **Board** of Thoracic Surgeons
American **Medical** Association
Assoc. of Military Surgeons of the United States
Cleveland Vascular Society
International College of Surgeons
International Society for Endovascular Surgery
Ohio **Chapter** of **American** College of Surgeons
Ohio State Medical Association
Society of Thoracic Surgeons
Summit County **Medical** Society

DEPSOITION INDEX of
MICHAEL ODDI, MD

Page 4/11	Has given deposition before
Page 5/15	Has copy of patient record dated September 23, 1997 to November 3, 1997 encompassing the radiology report pathology report and operative report progress notes and nursing notes
Page 6/7	There is some decrease in life expectancy in a paraplegic patient because they tend to develop repeat urinary tract infections & sometimes other systemic infections
Page 6/20	Does not know Dr. Began
Page 6/23	Not familiar with the physiatrists that work at the Crystal Clinic
Page 7/1	I have a physiatrist who I refer patient to at the Edwin Shaw Rehabilitation Hospital
Page 7/9	Has no correspondence file between himself and Mr. Treadon
Page 7/11	No file even in existence
Page 7/15	Doesn't recall the exact date it was probably in January I had pneumonia then
Page 8/4	Dr.'s Telesz, Cawthon, Tawil, Chryssos, Kralik and Donahue
Page 8/10	I picked it up on a Saturday I was out of town on Friday
Page 8/16	Has not reviewed the testimony that the Spreadbury's gave
Page 8/19	Has not read the testimony of Dr. Sos
Page 8/22	Has reviewed the chest films of Mrs. Spreadbury
Page 8/25	I reviewed plain chest x-ray
Page 9/3	Has reviewed the CAT scan
Page 9/5	Probably in June or July then again in the past three weeks
Page 9/24	Has not reviewed the Edwin Shaw records
Page 10/10	Has not had any publications

Page 10/14 Needs to up date CV as he has a few publications

Page 10/23 There was a fairly thick textbook not a surgical book basically general medicine called a five minute consult 1was asked to author a chapter on thoracic outlet syndrome years ago

Page 11/8 A compendium of every medical subject imaginable it's got a two page blush on each thing two pages on chronic lymphocytic leukemia & on aortic insufficiency thoracic outlet syndrome

Page 11/14 General Medical book

Page 11/17 They do another every year

Page 11/19 It has been unchanged for the past 6 or 7 years

Page 12/12 Can't really recall the specifics of the case, it was in Stark Cty., and the attorneys worked for Buckingham, Doolittle

Page 13/1 1was asked to render an opinion about a case involving wrongful death suit in a patient who had an esophagectomy for esophageal carcinoma years ago

Page 13/5 At the time 1worked for an attorney at Jacobson, Maynard & Kalur in Cleveland

Page 13/18 Only a couple of times

Page 13/23 I worked for Mr. Ockerman I know Mr. Schobert

Page 14/23 Somewhere between 9 and 10 hours

Page 15/1 Charges hourly for medical legal records review is $250

Page 15/4 Deposition time is $350

Page 15/7 The only one I know is Dr.'s Menia and Dr. Chryssos I only know by reputation

Page 15/16 Has not had the chance to talk to Dr. Menia

Page 15/24 Whether or not there was a departure from the standard of care relating to the care in a patient who turned out to have a traumatic rupture of a aorta

Page 16/5 That is where my expertise lies

Page 16/13 Will not be offering any opinions as to whether or not the radiologist met the standard of care

Page 17/18 I did search for a few papers concerning the treatment of traumatic rupture of the aorta

Page 17/23 I went to the medical library asked them to do it I presume they used medline or grateful med

Page 18/4 The library did return article on it

Page 18/12 The ones that I thought were pertinent

Page 18/15 They are additional information

Page 18/23 Attended Ohio State University

Page 18/25 Received degree in 1972

Page 19/3 Did internship at Walter Reed for one year in general surgery

Page 19/6 Between '73 and '77 complete 4 year program in general surgery
At Walter Reed

Page 19/11 Did two years of residency at Brooke Army Medical Center

Page 19/12 Cardiothoracic

Page 19/16 Fort Sam Houston, San Antonio, Tx

Page 19/25 Residency & fellowship in cardiothoracic is pretty much the same thing regardless of what people call it

Page 20/15 Was 1980 when I became certified in thoracic

Page 20/18 Became certified in general surgery in 1978

Page 20/22 Everyone who goes through residency learns how to approach radiology interpretation of specific x-ray studies

Page 21/4 Although I will say the CAT scans that we used to read in 1970 are a poor distant cousin to the ones we have today

Page 21/12 I always look at one with a radiologist because if I miss something he'll point it out

Page 2211	I was in the military for 4 years beyond that I spent 3 in West Germany at Landstuhl as assistant chief of thoracic surgery then chief for 2 years
Page 2215	I was at Letterman Army Medical Center at the presidio in San Francisco for one year
Page 22/9	I am from Columbus I was loolting for something in Ohio and the two surgeons were looking for someone to join them
Page 22113	I ended up in Akron
Page 22/20	It remained the same from '83 through the present
Page 22/24	Has never been insured by Mutual Assurance of Alabama
Page 2314	Doesn't really know
Page 231 7	Is certain it is not Medical Mutual
Page 23113	I do cardiothoracic peripheral vascular surgery that involves doing coronary bypass surgery valve repair and replacement surgery
Page 23116	We do a fair amount of pacemakers
Page 23/17	We do a lot of pulmonary surgeries for lung cancer, esophageal surgery for arterial plague involving the carotid artery, abdominal aorta & its branches & lower extremity arteries
Page 2418	There is no thoracic residency program at Altron General
Page 2419	It's general surgery residency
Page 24115	We instruct general surgery residents in thoracic surgical problems
Page 24/20	There has never been an AMA certified thoracic surgery at Akron General
Page 2514	Is certified is ATLS
Page 2516	Obtained certification in November of 1998
Page 25/12	Thought it would be wise to do that since we deal with a fair number of trauma patients I'm trying to convince my partners it would be a good idea
Page 25/16	The surgeon who runs the program at Akron General suggested to me about 1 ½ years ago it would be wise to think about it

Page 25/24 2 or 3 years I think it's 3 years

Page 26/3 I did save the materials from the ATLS

Page 26/7 Since last November

Page 26/12 Tlie ATLS course has been devised & developed by American College of Surgeon committee on trauma sometime in 1980

Page 26/23 Doesn't hold any certifications in ACLS

Page 27/1 The last holding for that was 1982

Page 27/6 We have a rotating call schedule whoever is on call for our service on a particular evening is also available for trauma

Page 27/12 Peripheral arteries

Page 27/19 I think I have 4 cases personally, probably assisted on one or two others

Page 28/10 His initial evaluation of this patient as the case was presented to him by the emergency medicine physician & his review of the initial radiographic study

Page 28/15 Providing for fairly close daily follow-up while the patient was in intensive care

Page 29/4 Before I began to look through the medical records

Page 29/11 I don't recall any specific conversation I would suppose that Mr. Treadon would have asked me to review the medical records with the idea that Dr. Tawil had departed from the standard of care since that was the allegation

Page 30/5 I was called in an emergency room emergency medicine situation

Page 30/12 First you try to get some idea of mechanism of the injury at the accident, you project the injuries might be

Page 30 15 You obtain that either from the paramedics written report or from the paramedic personally if you arrive while they are still there

Page 30/18 Cursory physical examination involving the so called ABCs of ATLS management by the time you get to the emergency room the emergency medicine residents have already done that

Page 31/1	By the time we get there everything is taken care of pretty much
Page 31/6	Try to determine whether the patient's circulation is adequate
Page 31/8	You obviously depend on blood flow for brain function, kidney function, liver function unless there is adequate blood pressure
Page 31/17	You palpate for the peripheral pulses in terms of strength and pulse rate, how the extremities look
Page 32/5	The next thing obviously once you determine that the patient has an adequate blood pressure is fairly stable
Page 32/8	Secondary assessment in which you palpate the chest wall itself to look for any rib fractures, evidence of ecchymosis or bruising in the skin and subcutaneous tissue
Page 3212	If the patient is awake you want to know whether or not they grimace with pain when you touch certain areas
Page 32/14	You push on the ribs or the sternum look for evidence of break in the skin that might be of concern in terms of possible penetrating injury
Page 32/17	You get a kind of expeditious chest x-ray to look for any evidence of rib fractures, pneumothorax with a collapsed lung
Page 33/5	They certainly are relevant if someone who is fairly young, otherwise healthy, it takes a fair impact to break a number of ribs
Page 33/23	That was my impression she had 2 or 3 back operations in the past by the record
Page 33/25	Didn't see any evidence of overwhelming medical problems
Page 34/3	After the dust settled there was more than the initial x-rays there were 8 ribs on the left 3 or 4 on the right
Page 34/11	Any time you have the first rib especially the first rib fracture that requires a pretty powerful injury
Page 34/18	You would look for the left common, left subclavian artery, any intercostal arteries that are in proximity to those ribs that are fractured
Page 35/6	Significant pleural fluid accumulation, more commonly on the left than the right
Page 35/9	Because that is where the descending aorta is but I'm not sure why

Page 35/13 Again rib fractures that is a prominent sign, especially the first and second ribs as you point out

Page 35/16 What is called a widened mediastinum is also significant

Page 35/18 In terms of major vascular injury inside the chest from blunt trauma we can talk about right deviation of the trachea when the aorta gets injured

Page 35/23 It can also lower the left main stem bronchus so the angle between the trachea & bronchus is increased

Page 36/1 If you have an NG tube or nasogastric tube down the patient to decompress the stomach that very common will be deviated toward the right for the same reason the trachea is

Page 36/5 There is also talk about pleural or apical capping in the pleural space that relates to blood accumulation or hematoma in the apex

Page 36/15 Anytime you have one of them in the appropriate setting you have to think about it

Page 35/22 Possible major vascular injury inside the chest

Page 36/25 She had bilateral pleural fluid, she had obvious rib fractures she had what was thought to be widening of the mediastinum

Page 37/3 Doesn't recall whether she had a nasogastric tube when she had the initial chest x-ray or not

Page 37/11 Because I knew I would take a look at them again sometime

Page 37/22 While the quality of the portable chest x-rays are notoriously inadequate in terms of defining anything

Page 37/25 To look at the lung fields make sure that the lungs aren't collapsed

Page 38/4 The standard A/P portable chest film especially in large patients will almost show a widened mediastinum

Page 38/18 Presuming the patient is stable enough to be transported we go to the CT scanner in the radiology department

Page 38/24 There are a lot of people at this point in time who because of the fairly good definition you get on Ct scan will make a diagnosis on the basis of the scan

Page 39119	Depends on the radiologist if it is some one that I have worked with for years like at Akron General I have implicit faith in their interpretation
Page 40/7	If you presume that someone is a board certified radiologist
Page 40112	I'm not sure I exactly whether I would rush the patient over to the aortograph suite at that point or not, probably would not
Page 40116	Because of the potential for complications of arteriogram
Page 40124	We're looking at things retrospectively
Page 41124	I haven't reviewed that recently, I think that given the clinical situation the CAT scan has no evidence of any great vessel injury according to the interpretation of the experienced radiologist
Page 42/6	As the thoracic consultant
Page 42116	I'm not the radiologist there are certain subtle things I miss
Page 4314	I was able to see the finding on the CAT scan that were suspicious for injury to the aorta
Page 4319	I found them as they were pointed out to me
Page 43/15	There was slight irregularity of the aortic contour on one of the slices
Page 43/17	There was a kind of a radiolucent line on one of the other slides that suggested perhaps an intimal tear
Page43123	Distorted or irregular
Page 43/25	Perhaps just beyond the aortic arch
Page 4413	It could be suggestive of an aortic injury could be remnant of vascular ring that I have seen picture of in the past
Page 44/16	They do that all the time the radiologist will say I'm not sure about this one area
Page 44118	We get additional cuts that is their area of expertise
Page 44120	If they feel additional views are necessary I would certainly never argue that at all
Page 45/6	I think I would

Page 45/9 I want to have a personal conversation with a radiologist maybe have another opinion

Page 4613 Not the x-ray the CT scan

Page 46/5 I took that entire study put it on the large view box in the radiology department at Akron General

Page 46/1 1 I told the radiologist this was a case from a couple years ago she said there was a lot of subcu air I would be concerned about possible tracheal injury

Page 46/22 We do that clinically all the time we focus on a particular problem

Page 46/24 Clinicians do that, radiologists do that dermatologists do that

Page 47/1 You focus on an area that is very obviously abnormal you miss something it happens

Page 47/11 Can I do that again if somebody gave me a study maybe may be not

Page 47/20 That pure speculation from his deposition testimony where he was trained

Page 48/1 I know that he came from Yale University with an excellent reputation basically international reputation

Page 48/6 Dr. Gahaus

Page 48/16 I don't recall specific questions basically you submit an application, including 100 consecutive cases

Page 48/18 The board sends you what amounts to being an open book test

Page 49/11 About whether to go the aortograph or observe the patient for the next several hours

Page 49118 Any irregularity of the aortic contour that I couldn't ascribe to obvious atheromatous disease in older patients

Page 49/22 What is called a wcdge-shaped defect in the aortic wall basically anything that doesn't look smooth

Page 50/2 You see mediastinal hematoma in chest trauma all the time

Page 50/14 Depending on the clinical situation although I think if there were any suspicious findings on the CT scan I would probably recommend an aortogram to be on the safe side

Page 50/19 Any kind of clinical instability drops in blood pressure, drops in hematocrit or blood count anything suggesting hypovolemia which is decreasing in blood pressure

Page 51/8 Doesn't recall any changes in respiratory status

Page 51/11 I certainly should have, but I don't recall anything specific

Page 51/17 The only note in the physician's progress notes is from Dr. Telesz at 6:00 pm which relates to very transient decrease in blood pressure that responded fairly adequately as far as I can tell to some increase in I.V. fluid administration

Page 52/4 The nurse's note are much more legible than the doctors' notes, they state that right around 5:15 pm the patient was fairly combative to Dr. Tawil's attempt to do the bronchoscope at that time

Page 52/13 Anybody who exhibits increased anxiety or respiratory difficulty could have some bleeding inside the chest

Page 53/3 It is a terrible thing to admit but if you read the medical literature there are a certain percentage of patients who have successful thoracic aortic rupture repair operations

Page 53/11 Variability in blood supply to the spinal cord and the fact that it's necessary to clamp off a fairly good portion of the thoracic aorta to do this operation

Page 53/16 Three to twenty percent will be paraplegic after these operations

Page 54/1 I think it had to do with clamping of the aorta the spinal cord ischemia when that happened

Page 54/15 Believes it was the surgery that caused her to become a paraplegic

Page 54/24 Classically the way to do this was to use what some people call a clamp and sew technique

Page 55/1 Clamp the aorta both above and proximal and distal to the injury open the hematoma see exactly what the situation is repair the aorta or replace that part with a prosthetic tube graft

Page 55/10 The other way to do this provide some type of shunting of blood flow to the lower extremities around the area that you are working on

Page 55/14 One is heparinized shunt to go around the other is called a partial bypass with a heparinized circuit then you don't have to give systemic heparin

Page 55118 My way is clamp and sew

Page 55/24 I believe the contribution from the anterior spinal artery may be very significant from those intercostal branches of the aorta and part of the aorta that is being clamped off

Page 56/20 It's scientific principle

Page 57/7 It depends on the particular surgeon I don't know what Dr. Chryssos and Dr. Kralik prefer to do

Page 57/12 Doesn't always take less than 30 minutes

Page 58/1 From the medical records it was about 6:00 pm on the 23rd

Page 58/4 To increase in I.V. fluids

Page 58/7 Dr. Telesz recorded the pressure was 70 to 80 systolic

Page 58/11 On the 24th at about 9:00 am

Page 58/14 Doesn't recall the number

Page 58/17 The recorded pressure at 9:10 am on the 24th was 35 over 21 as recorded by arterial line

Page 58/23 You would have to presume there was acute volume loss blood loss that occurred right at that time

Page 59/2 The most likely source is an acute expansion of the hematoma that she turned out to have secondary to the aorta injury

Page 59111 If it's reliable blood pressure reading I don't see any obvious explanation for that

Page 59/18 Typically a portion of the aorta wall will be torn by blood flow will be contained by surrounding tissue typically the adventitia, which is the internal lining of the aorta and at least part of the media which is the muscle layer of the middle layer is torn

Page 60/23 Decrease in blood flow through the artery branches that supply or arterial branches that contribute to the anterior spinal artery

Page 61/3 Again it's variable from one person to the next, some of the intercostal arteries that originate under each rib can provide a contribution and the anterior spinal artery

Page 61/11 It depends how much blood is getting lost

Page 62/5 Has read Dr. Tawil's deposition

Page 62118 Believes that the surgery is cause of her being a paraplegic

Page 62/25 She may not have been paraplegic prior to the surgery

Page 63/3 Has read Dr. Tawil's admission and discharge summary

Page 6317 Dr/ Kralik mentioiicd she was partially sedated it was really impossible to do an adequate neurological exam on her pre-operatively

Page 63/22 As I recall she was moving her toes but the degree of movement was not thought to be what would be expected on the basis of how well she moving her upper extremities

Page 65/14 There is nothing in the physicians' or nurses' not about her moving her toes my recollection is that Dr. Kralik mentioned he had been to see the patient that morning when he was called after she dropped her blood pressure

Page 65/18 I thought he mentioned she moved her toes I could be mistaken

Page 65/23 Will go through Dr. Kraliks' deposition again

Page 6612 Can't remember his exact response

Page 66/8 Doesn't recall him indicating the possibility of surgery being the cause of the paraplegia

Page 66/11 I think he mentioned that because the patient was hypotensive in the early part of the operation

Page 66/13 There was also some increased difficulty of the procedure because of the mild anomaly she had in her aorta arch

Page 66/15 It made the operation a bit more difficult he thought the patient contributed to it because basically the patient was without a blood pressure I guess for several minutes

Page 66/22 I think it's kind of a testimonial to the surgical expertise at this point that she is even alive at this point

Page 67/7 Will have to go back and review his deposition

Page 67/16	Did not see that the findings on the aortogram
Page 67/22	I'm trying to read his mind as far as I can tell it makes the decision where you can safely put the clamp proximal to the subclavian artery a bit problematic
Page 68/6	It is determined as to where you place the clamp
Page 68/10	It was described by Dr. Chryssos
Page 69/6	Had the records prior to receiving the x-rays