THE STATE of OHIO,
: SS:
COUNTS of LORAIN.

IN THE COURT OF COMMON PLEAS

GLEN T. DIAMOND, et al.,
plaintiffs,

vs. : Case No. 96CV117098
: Judge Zaleski

WILLIAM B. SAXBE, M.D., et al.,
defendants.

Deposition of RAYMOND P. ONDERS, 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 University Hospitals, 11100 Euclid Avenue, Cleveland, Ohio, on TUESDAY, MARCH 10TH, 1998 commencing at 9:55 a.m. pursuant to agreement of counsel.

APPEARANCES:

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I N D E X

WITNESS: RAYMOND P. ONDERS, M.D.

DR. ONDERS DEPOSITION EXHIBITS	MARKED
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(IF ASCII DISK ORDERED, SEE BACK COVER)

RAYMOND P. ONDERS, M.D.

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

MISS KOLIS: Doctor, is it Dr. Onders, am I as pronouncing that correctly?

THE WITNESS: Um-hum.

MISS KOLIS: That usually makes a favorable impression.

As you know I'm Donna Kolis, I've been retained to represent Glen Diamond in this lawsuit.

It's my understanding that you are ready, willing and able to give testimony in court on behalf of Dr. Saxbe; am I correct in my understanding?

THE WITNESS: Yes.

CROSS-EXAMINATION

BY MISS KOLIS:

Q. I'm going to hand you a copy of what I believe is the one and only hopefully report that

you authored in this case.
A. Yes, I did.
Q. Could you identify that is the report you authored?
A. Yes, it is.
Q. There doesn't appear to be a date on the report, unless it's at the end. Can you tell me approximately when you wrote this report? If you don't know it's okay.
A. I don't know.
MR. STRONG: Whatever the cutoff date for that is, we can go with the proposition it was in advance of that. If you want to know I'll check.
MISS KOLIS: That's okay. There was no date on the report. We'll have that marked as Plaintiff's Exhibit A.
Q. Doctor, to confirm since you've taken an oath to tell the truth, in fact that is the only report you've written in this matter?
A. Yes.
Q. It's my recollection that in preparing that report you reviewed the medical records?
A. Correct.
Q. You say you reviewed depositions, can I

assume the deposition first of all Dr. Saxbe, the defendant?
A. Correct.
Q. Did you also read Mr. Diamond's deposition?
A. Yes, I did.
Q. It says you reviewed x-rays from north Florida, can you tell me specifically what x-rays you looked at?
A. A KUB, regular abdominal x-rays, ERCP.
Q. Did counsel for the defense provide you with those x-rays, were those x-rays films that you felt you needed to see to draw your conclusion in this matter?
A. They just provided them.
Q. I never deal in any particular order than randomly, as you will find out throughout this deposition.

Did the KUB and ERCP provide you with any information that forms the basis of your opinions?
A. No.
Q. Something to look at?
A. Right.
Q. Fair enough.

I've been handed your CV, have not

had the opportunity to go through it with any amount of thoroughness. Let's ask you a few background questions.

Your medical school training I see was at Northeastern, correct?

A. Um-hum.

Q. You completed that in 1988?

A. Yes.

Q. Following that you did your surgical residency here; is that right?

A. Correct.

Q. It looks like it was a five year surgical residency?

A. Correct.

Q. Can I assume shortly thereafter you became Boarded?

A. Correct.

Q. Same year, 1993 or '94?

A. Took the written exam in '93, oral in January of '94.

Q. Have you spent your medical career since 1988 here at University Hospitals?

A. No.

Q. Then I'm going to have to look, tell me where you've been?

A. In the United States Air Force for four years prior to coming back as director of minimally invasive surgery.

Q. You were a surgeon?

A. Surgery and the director of minimally invasive surgery at Wright Patterson.

Q. You didn't get to fly any planes?

A. No.

Q. You did the other job.

I note that on the report you authored your title is Director of Minimally Invasive Surgery?

A. Correct.

Q. Tell me what that encompasses.

A. At this facility I'm in charge of advanced laparoscopy, credentialing in new providers, in charge of the quality assurance for laparoscopic procedures.

Q. Let me ask you a little bit about that. When you say you are in charge of credentialing in all new providers, does that mean credentialing the doctors who perform laparoscopic procedures?

A. Advanced laparscopic and general surgery.

Q. Define advanced laparoscopic.

A. Basically we do laparoscopic

cholecystectomies, advanced is everything else, splenectomy, pancreatectomy, liver resection, we now do about all cases of laparoscopy.

Q. I would assume then you are credentialing at the higher echelon of these kinds of surgery; do you also have any input into the credentialing of physicians who perform basic laparscopic cholecystectomies?

A. Yes, I do. As we're changing obviously one of the reasons I'm the new director is there wasn't a director before as we started outlining what we wanted for the continuous quality assurance, the criteria are changing.

Q. What are your responsibilities as far as didn't you say you were the director of QA, that fell within your responsibilities?

A. In the Air Force I was the director of quality assurance. Here at the hospital we have a quality assurance group.

Q. As a part of the quality assurance group do you evaluate the conduct of physicians in performing these kinds of procedures?

A. Yeah. Proctoring new physicians during advanced laparoscopy, that's part of the quality assurance, observing them.

Q. Are you currently serving on any peer review committees?
A. The quality assurance is a peer review committee.
Q. I assume you don't call it peer review?
A. No. I go to the peer review meetings.
Q. I don't know a great way to ask this question so let's see if I can find at least a simple way: Would you agree with me the purpose of quality assurance or peer review is to point out to doctors that there are some things they need to do better in a general sense?
A. Quality assurance is trying to make sure the patient gets good quality care.
Q. Sure, absolutely. Part of making sure that the patients get good quality care is aiding and assisting a physician who may be using substandard techniques, you would agree with that, correct? You are second guessing the doctor or aiding and assessing good patient care?
A. Most of the time not second guessing. There are so many multiple ways to do a procedure, it's to help a physician would did a procedure do it the most expeditious way and better for the patient outcome.

Q. In reviewing this case, what do you feel was the cause of Mr. Diamond's bile leak?
A. It was a cystic duct leak.
Q. There was no question in your mind that is what it was?
A. Correct, cystic duct leak.
Q. Cystic duct leaks are a known and common complication of lap chole?
A. Known and common complication.
Q. Would you say that was a known and common complication of open cholecystectomy?
A. Yes.
Q. So it's not a brand new complication that came into existence at the same time as lap chole did, correct?
A. No.
Q. Based on your training, background and education, how long would you say that ERCP has been available in United States hospitals?
A. That is a hard question to answer. Purely because it's different in different areas of the United States. There is a huge dichotomy where ERCP is common, available, not available.
Q. Let's start with the simple question, if you know the answer: When was ERCP first introduced?

A. I'm not sure of the exact, 1980's.
Q. You think it was the 1980's?
A. First introduced in major centers.
Q. What was the purpose of --
A. I'm not sure, in the 1980's.
Q. What was the purpose of ERCP?
A. To identify leaks of the common bile duct and look for tumors, for obstructive jaundice.
Q. Do you know whether ERCP was used for that purpose in conjunction with open cholecystectomy before the advent of laparoscopic cholecystectomy?
A. ERCP was not that common in the late 1980's, wasn't common in the early 1990's. There are still areas of the country where ERCP can't be performed.
Q. Areas where it can't be?
A. Can't be, it's a training problem. Gastroenterologists in most areas are required to have specialized training. In our center we have two doctors that we feel are qualified to do ERCP.
Q. Who is that?
A. Dr. Chak and Dr. Sivak.
Q. I was going to guess Chak.
A. They may have brought in a new one that does it.
Q. You don't do ERCP, correct?

A. No.
Q. That is something generally done by a gastroenterologist?
A. Some surgeons do it, it requires further training.
Q. Have you had an opportunity to talk to Dr. Saxbe?
A. No.
Q. Everything you know is based on Dr. Saxbe's deposition --
A. Review of the medical record.
Q. -- in terms of what his thinking was in this particular case?
A. That and the medical records.
Q. Fair enough. I guess we should get right to what is important as I see it, sort it out.

When you wrote your report you indicated that in **1995** I think, in **1995** it was not common around the country -- giving it a point of reference, the preceding sentence was, "Over the last several years as laparscopic cholecystectomy became much more common around the United States, it is much more frequent to undergo an ERCP early in the course as opposed to initially draining it."

When you said in 1995 this was not common around the country, which thing was not common around the country, the use of ERCP to drain a collection of bile?

A. ERCP is not used to drain a collection of bile.

Q. I stand corrected. ERCP as a diagnostic tool to determine the cause of a bile leak?

A. Absolutely. In 1995 I would not have used an ERCP to diagnose.

Q. Why not?

A. I was stationed in North Dakota and there was no gastroenterologist in that area to do an ERCP. It was more to the patient's detriment to have an ERCP done.

Q. When you were in North Dakota in 1995 you are indicating that you would not have used an ERCP because there wasn't a gastroenterologist, correct?

A. Nobody that I felt did enough of them to be confident that we can do it without injuring the patient. The other aspect is that data shows us you don't need an ERCP.

Q. Do you still believe that there is data to support you don't need an ERCP?

A. There is a recent article in the literature,

recent as 1996 from a cystic duct study group that looks at a high percentage of patients who are treated by drainage alone have the best outcomes.

Q. When these people are treated by drainage alone, you are referring to what kind of drainage?

A. Catheter.

Q. Jackson-Pratt?

A. Jackson or one placed via ultrasound, which wouldn't tend to be as a big as a Jackson-Pratt drain.

Q. Would you say it falls within the standard of care following the placement of a Jackson-Pratt as a method of draining a collection of bile to do a follow-up study to see if it has cleared the collection?

A. A Jackson-Pratt you follow drainage output, if the drainage stops you remove it, see how the patient does. Many times you don't need a follow-up. It's not common and cost effective to repeat ultrasound based on the clinical trial.

Q. How much does it cost to have a sonogram done to firm the collection is cleared at the conclusion of a Jackson-Pratt drainage?

A. I'm not sure of that.

Q. Thousands and thousands?

A. 5, $600.

Q. Do you think it is more cost effective to follow up with a study to make sure the entire collection is drained, rather than let the patient leave the hospital, be rehospitalized at a later time?

MR. STRONG: I object. You're making a generalized proposition with a specific outcome.

MISS KOLIS: I'm asking a general proposition.

MR. STRONG: You attach a specific outcome. I object to both form and substance. Go ahead, Doctor.

A. No. I don't know what I'm saying no to. Most patients I would treat with a closed suction drain for any fluid accumulation I would not follow-up with a study before I remove it. When the drainage stops I would just remove it.

Q. In this case when Mr. Diamond was discharged from Allen Memorial Hospital by Mr. Saxbe do you believe he was still draining any fluid from the Jackson-Pratt or had the drainage stopped?

A. I believe he was still draining fluid, down to less than an ounce a day.

Q. Is the ounce a day reference what Dr. Saxbe found at the final examination in his office?
A. Correct.
Q. I'm asking you if you have studied these records sufficiently to determine the description of the output from the Jackson-Pratt on the date he was discharged?
A. If I'm correct it was serous in nature, not bilious, less than an ounce a day, he removed the tube.
Q. So that the record is absolutely clear, you do not feel the standard of care requires a simple diagnostic follow-up test to make sure that the bile has resolved?
A. That's correct.
Q. Has this hospital formulated any set of standards regarding discharge of patients with bile leaks?
A. No.
Q. Have you read the deposition of my expert, Dr. Richard Schanger?
A. Yes, I have.
Q. Let's ask you some different questions.
Do you find it remarkable that in Dr. Schlanger's experience he's not seen a

situation like this where they didn't use an ERCP?
A. Yes, I do find it remarkable. In published studies up to 25 percent of all patients did not have any diagnostic study such as ERCP.
Q. What published studies are you relying upon?
A. Surgicaf Endoscopy, 1996.
Q. Doctor, you are looking at some note cards at the moment?
A. The note cards have the reference there.
Q. Did you do a MEDLINE search to find this, how did you find this particular reference?
A. When I was writing a chapter on cholecystectomy for common bile duct stones.
Q. These are your note cards from the writing you did, not something you did in preparation for this case?
A. I wrote that down in case you wanted a reference today.
Q. Fair enough. You can have that back.
A. I have a series of articles.
Q. Did you rely upon any other articles in writing this report?
A. Nothing in specific. Obviously in my job here I'm always reading about laparoscopic cholecystectomy and their problems. I'm constantly

doing MEDLINE searches for residents for other articles I'm publishing.

Q. Let's talk about cystic duct leaks since that is what the issue is in this case, correct?

A. Um-hum.

Q. Generally speaking, when there is a cystic duct leak following a cholecystectomy, whether it's open or done laparoscopically, what is the cause of the cystic duct leak?

A. It's a multi-factorial cause. In the open there is probably a lot more leaks than we realize, we left a drain in everything. The actual studies now look at perspectively you do scans on people, significant number of people have asymptomatic cystic duct leak. 7 to 8 percent have bile leak after laparoscopic cholecystectomy, cystic duct leaks are probably more common, caused by the clip being dislodged and the backup pressure, loop being too tight, necrosis of the cystic duct.

Q. What caused the cystic duct leak in this case, do you have an opinion?

A. I don't have an opinion, it occurs many times.

Q. Will you be offering an opinion as to what the most likely cause of the cystic duct leak was

in this case?
A. The most likely is the clip doesn't completely control the cystic duct so there is the leak.
Q. Is that your opinion what happened in this matter?
A. I can't -- most of the time we don't know exactly why you get a cystic duct leak. We know you have one, we have a multitude of different ways to handle that.
MR. STRONG: I would object to asking what the common causes are. As you heard he's not able to say specifically with probability which one of those.
Q. Generally speaking what is the treatment for a cystic duct leak?
A. There is no specific treatment for cystic duct leak, there is no 100 percent way to treat it, there is a multitude of different ways to treat them.
Q. Let's go through what those are.
A. Again, looking at the recent, even the older data, the most common case is the standard is to drain it.
Q. What does the drainage do, explain to me?

A. What you want to do with drainage, you want to control fluid accumulation and control what we call fistula. Certain cases depend on whether or not if you have an idea of why you have a cystic duct leak you prevent it, if you have a simple cystic duct leak, drainage would be a good way to treat it with the least morbidity to the patient.

Q. How does the duct leak then stop?

A. Most of the time it will heal if you lower the pressure, the bile goes to the duodenum, lowers the pressure, the cystic duct purely heals on its own.

Q. I don't want to sound too uneducated, this is an injury that heals itself and there are scars, like any other place in the body?

A. Scar formation itself is critical in this. Scar formation is the reason why drainage is many times the best way to treat this.

Q. I just want to know, to make sure, there is no injury of the common bile duct in this case of course?

A. No, there is not.

Q. How can you be certain as a physician that adequate scar formation has occurred in any given case?

A. In any given case it's purely on the drain output. If you have a drain to collect this or if you know if it is a small leak or big leak, the correlation, you feel that appropriate scar formation occurs when the drainage no longer looks like it contains bile.

Q. I'm making this too simple.

A. Yes, when the drain stops draining bile you assume it's now all going in the other direction.

Q. Is it possible that when you initially place a drain, that there is another accumulation of bile in a different location that wouldn't be addressed by that drain?

A. Yes, there is many times when you say fluid collection, if we would do an ultrasound on everyone that had a laparoscopic cholecystectomy, 15 percent will have a fluid collection after surgery.

Too many times if you have a fluid collection -- that's why I'm not saying that you need to do a follow-up scan -- if you have a fluid collection causing a problem, you are draining bile appropriately, a fluid collection is not a problem. By ultrasound 10 to 15 percent of patients a week after surgery have fluid in the

area.

Q. When somebody is symptomatic as Mr. Diamond was, he could have a problem I take it with a bile collection, right?

A. Correct.

Q. The question I'm asking is this: You do one sonogram, that is what occurred in this case, right? Do you think he should, Dr. Saxbe should have done a CAT scan instead of a sonogram?

A. Sonogram and CAT scan are equal in this respect.

Q. Equally acceptable for evaluation of fluid accumulation?

A. Yes.

Q. Fair enough.

Because his Jackson-Pratt did drain bilious fluid for a few days -- you agree with me it did on his admission?

A. Yes.

Q. Could one reasonably infer that there may be additional collection forming that might not be addressed by the Jackson-Pratt that was inserted?

A. Looking at that entire picture, the patient got better, the Jackson-Pratt drained bile, the patient got better enough to go home, usually that

is what we go by. Whether there are follow-up studies, patients are doing well initially, drain bile.

Q. Let me ask you to define what you mean by got better?

A. Patient was discharged from the hospital, he's eating normally, the ileus resolved, I think the laboratory tests returned to normal.

Q. Is the ileus related to the bile leak?

A. Yes.

Q. But he was still draining some fluid out the Jackson-Pratt at the time of discharge, you agree with that or not?

A. Yes.

Q. The fact that it was no longer -- I'm going to say bile tinged, I think I'm using a word out of there -- of what significance is that to you?

A. Whenever we place a drain in the body cavity there is peritoneal fluid, it will drain fluid from the peritoneal cavity.

Q. Why did they leave in the drain at the time of discharge if it is serosanguinous fluid, didn't have bile in it?

A. At the time of discharge?

Q. Yes.

A. To be sure that the patient continues to do well, there is no problem with leaving the drain.

Q. Simply asking.

At trial are you going to indicate that you believe there was adequate scar formation that stopped the bile leak as of the time of discharge, I think that was September 26th?

A. Or at the time of follow-up when the drain was removed?

Q. 26th, 29th, I need to know what you are going to testify to.

A. From the notes in the chart by the outpatient visit no longer bile tinged, less than one ounce, both of those criterion the patient was still doing well at home, doing well, I would remove the drain.

Q. My question is: Is it going to be your testimony adequate scar formation to prevent bile leak had occurred by that point in time?

A. You are asking a question nobody can know. We don't know what the scar formation is. By our criterion if drainage is down, patient is doing well, he's at home, I would assume that the scar tissue is good. There is no criterion the scar tissues is good. His presentation is very late in

the course, there should have been scar tissue, he shouldn't have had a leak to begin with.

Q. Why did he end up in the hospital in Florida?

A. He releaked from the cystic duct.

Q. When you say releaked, what do you mean that he releaked?

A. I believe again, from the data that is presented, that he initially had the leak controlled, the leak stopped, for some reason he began to releak again.

Q. Are you going to testify that to a reasonable degree of medical probability initially the duct leak healed over, then somehow spontaneously reopened?

A. From the patient's presentation where he got better, the drain stopped draining, his labs returned to normal, then the time frame where he was doing well, I think it releaked. I think that is definitely a possibility.

Q. What do you mean by releaked?

A. I think the leak stopped leaking, then for whatever reason it started leaking again.

Q. I understand how you answered. I'm going to ask it my way, see if you can answer, if you can't, say that. You are allowed to say I can't answer.

Do you have an opinion, Doctor, there was adequate scar formation at the site of the cystic duct leak such that first of all the duct leak healed over at the time of his discharge by Dr. Saxbe on September 29th?

A. Yeah, I believe he had stopped leaking. By all the criterion available he had stopped leaking.

Q. He spontaneously reopened that duct leak?

A. No. This is an interesting case from two aspects. One, it is a very late leak to begin with which is very uncommon to present with a late leak, Yes, he absolutely releaked. The leak stopped and releaked.

Q. That's the highest probability in your own mind as a physician as to the course of events?

A. That's what I believe, looking at the medical record.

Q. Let's talk about this issue of late leak. When you say late leak, in the course of events are you talking about his representation on the 18th of September, are you calling that the late leak?

A. His first rehospitalization, yes, that is the late cystic duct leak.

Q. There were six days, he was discharged on the 13th of September, are we in agreement with that?

A. I have to look.
Q. Can you look?
A. Time of the surgery to presentation --
MR. HERBERT: Surgery was the 11th.
A. Representation was the 18th, that is seven days, that is a late leak.
Q. Define a late leak.
A. Most cystic duct leaks would occur from soon after presentation to within days.
Q. Didn't you just earlier in this deposition tell me that -- I can't remember what percentage you said -- a percentage of people, you believe that everyone if they have a sonogram following a cholecystectomy would show a collection of fluid?
A. Some free fluid.
Q. That free fluid being bile?
A. No.
Q. I need to be clear.
A. If you look at the Scandinavian studies, randomly doing HIDA scans, 6 percent of people leak bile after cholecystectomy.
Q. From where are they leaking that bile?
A. Probably the cystic duct.
Q. So if he started out with a slow leak, he

might not have necessarily been symptomatic?
A. No, slow leaks tend be symptomatic as much as large leaks.
Q. Do you have a medical opinion for the cause of the late leak?
A. No, I do not.
Q. What are the reasons for that, do you know of any?
A. A late leak would be secondary to a retained common bile duct stone. The liver function studies show that a retained common bile duct stone wasn't the reason for the late leak.
Q. In this case we don't have a retained stone?
A. No.
Q. Correct?
A. No, we don't.
Q. What are the other reasons for late leak?
A. I have no idea why this occurred.
Q. Is it described in the medical literature?
A. There is no authoritative thing on this. There are a multitude of reasons, cystic duct leaks are fairly common for different reasons, a lot of different reasons you can have one.
Q. As a physician, if you have a person with a cystic duct leak you treated by drainage, do you

advise your patient that there is a possibility that that duct leak might spontaneously reopen?

A. If they had a cystic duct leak?

Q. Yes.

A. I think the cystic duct leak there is always a possibility this may recur, it's on our initial consent form, cystic duct leak is outlined.

Q. On your initial consent for?

A. For the laparoscopic cholecystectomy. On the standard consent form we list bile leak as a

advise them of the possibility that this leak will spontaneously come back?

A. I think if they have had one still in the initial postoperative period, yes, it may come back.

Q. I'm asking you if that is what you do?

A. I never had that situation, I can't say what I would do.

Q. You've never had the situation where a person had a cystic duct leak?

A. I've had a cystic duct leak.
Q. My simple question is do you advise your patients when you discharge them after treating them for a cystic duct leak there is a possibility it will spontaneously reopen?
A. Yes.
Q. I gather that you evaluated what happened to Mr. Diamond at the hospital in Florida?
A. Yes.
Q. At the time that they determined to do an ERCP is it your understanding from the review of the records that he had completely stopped draining?
A. His bile you mean?
Q. Um-hum.
A. I'm not sure what question you are asking.
Q. Let me try to make it simpler.
The care and treatment given to Mr. Diamond in Florida was different than the care given by Dr. Saxbe, do you agree with that?
A. Initially the same care.
Q. Sure. That's fine. They subsequently did additional things, correct?
A. Correct.
Q. At the point they determined to do ERCP do

you recall from reviewing the record that his drain that had been placed for the biloma had completely stopped draining?

A. I would have to look at the record itself.

Q. Why don't you.

A. From my understanding is th t it still had fluid so --

Q. What kind of fluid?

A. I have to look.

MR. STRONG: If at any time you need to look at the records, Doctor, feel free to do so.

Q. I didn't tell you, this isn't a memory contest.

A. I remember the ERCP report, where it's at. On the date of **10-13**.

Q. Right.

A. I think the reason they repeated the scan is his temperature was elevated, not doing as well, The note **10-11** drainage stopped, subhepatic, patient was not doing well, they repeated the CT scan.

Q. So I think you just answered my question. The notes indicate that the drainage had stopped, correct?

A. But the patient was not doing well.
Q. Not doing well, what was the elevation of temperature?
A. Elevation of temperature, that would be an indication for rescanning, which they did. They saw fluid, placed another -- I don't know if they placed another catheter, did they at that time, 10-12?
Q. Didn't they decide to do ERCP?
A. ERCP. ERCP on 10-13.
Q. What does stenting do for a cystic duct leak?
A. Decreases pressure so it would heal on its own. You want a low pressure system.
Q. How does a low pressure system help?
A. It will heal on its own if it's flowing in the correct manner. It will collapse the cystic duct walls, they scar and close.
Q. That's the same result obtained by using a Jackson-Pratt drainage system?
A. The same result of healing.
Q. As far as stenting, are they equal in their efficacy for healing a cystic duct leak?
A. Yes. I think drainage alone, as I stated before, I think drainage alone is an accepted and common, good way to treat a cystic duct leak.

Q. Do you know whether or not there was a gastroenterologist who had privileges at Allen Memorial Hospital with sufficient training to have done an ERCP while Mr. Diamond was there in September of 1995?

A. I'm not aware. I'm not sure.

Q. Would you agree with me that Mr. Diamond was not so ill during the course of his hospitalization at Allen Memorial he would have been unsuitable to transfer to a facility where a gastroenterologist with appropriate skills to do an ERCP was located?

A. I'm not sure what you are asking. I think drainage of catheter alone --

Q. That's not my question.

MR. HERBERT: Are you asking him to assume that?

Q. Assuming that.

A. If you want to assume that the patient is doing very well, would I subject them to the risk of ERCP, the answer is no.

Q. That's not what I am asking you, although that's what Dr. Saxbe's lawyers will ask you at trial.

My question is do you agree with me Mr. Diamond was not too ill to have been

transferred to a different facility during his rehospitalization of September, 1995?

A. In a hypothetical patient like this?

Q. No, this patient.

A. This patient? A patient well enough to go home? A patient well enough to go home can be transferred if that is what you are asking.

Q. That is what I'm asking. There is no medical reason he couldn't be transferred somewhere else?

A. He was discharged home.

Q. So we don't get caught later, I need to know whether you would agree --

A. A patient that can be discharged home can be transferred to other hospitals.

Q. Do you usually have a gastroenterologist consult in a situation where you have a person who is returned with a cystic duct leak?

A. It depends on where I was practicing at at the time this occurred. If there is no gastroenterologist available I would not consult one.

Q. That goes without saying. Let me rephrase the question. I get the flavor of what you want to talk about.

If you were at a facility with a

gastroenterologist, I don't care qualified to do ERCP, with a patient who returned after a cholecystectomy with a bile leak, we will call it a bile leak, would you have the gastroenterologist come in and consult on the matter?

A. If I know I have a cystic duct leak, I have a drain controlling it, no, I would not. As a biliary tract surgeon it's one of our more common procedures, biliary tract procedures we can handle ourselves. Unless it's an ERCP, I would continue. I would not have the patient undergo an ERCP I thought would cause undue harm to the patient.

Q. Let me rephrase what I think you said. You are saying most biliary tract procedures that can be done by laparoscopic or open, you feel equipped as a surgeon in that area to formulate a plan of care?

A. I said initially if it was a cystic duct leak.

Q. Let's throw the cystic duct out. Let's talk about possibilities.

A. In his case if I was unsure where the patient was leaking I would think of obtaining an ERCP, then yes, I would probably, since I don't do ERCP, I would have consulted somebody that does ERCP.

Q. This particular case, can you agree with me there was no confirmation in the initial hospitalization, rehospitalization, by Dr. Saxbe that it was in fact a cystic duct leak?
A. We know it was a cystic duct leak. There was no confirmation in the initial hospitalization.
Q. In fact it was inference on his part?
A. What a very common inference as the articles I quoted high percentage of people treat them with drainage alone, not confirm. There is risk to confirming what the leak is.
Q. I appreciate you educating me. What I'm trying to do is ask questions, get direct answers. So obviously you are going to get your chance to tell the jury what you think. I'm going to ask simple questions, hopefully get simple answers.

My question I think we established through an answer you agree with me there was not confirmation, this was an inference on the part of Dr. Saxbe?
A. There was not confirmation this was a cystic duct leak.
Q. We agree that is the situation.

Given Mr. Diamond's presenting symptoms when he was rehospitalized what were the

possibilities as to the cause of the bile that was leaking?

A. When initially presented we do not know it was a bile leak.

Q. At the point the sonogram confirms that accumulation of fluid, I think they describe it I'm going to say around the liver, we will make it easy; do you agree that is what it indicated?

A. Um-hum.

Q. As a surgeon who does these kinds of procedures, what were the possibilities of the cause of an accumulation of fluid?

A. As I mentioned when an ultrasound is done on all patients, a lot of them we irrigate with fluid, it is not absorbed immediately, purely fluid. From there the next step is to see how the patient is doing, place a drain, see if it's bile or not.

Q. That was not the question I asked. So maybe you sort of got me to a better place.

Purely fluid was excluded because they obtained bile, correct?

A. At the time of drain placement?

Q. Yes.

A. Yes.

Q. Now at that juncture what were the

possibilities for the cause of the bile?
A. Must be coming from the biliary system, cystic duct leak, duct of Luschka leak, anywhere from the entire biliary system could be leaking.
Q. Could you exclude that there might have been an injury to the common bile duct?
A. That cannot be excluded but with the fact the liver enzymes were not elevated we can assume it was not a complete injury. I believe he had a nasogastric tube that had bile in it.
Q. Of what significance was that to you?
A. He didn't have a complete obstruction, bile had to get into the gastrointestinal tract.
Q. There were in fact other possibilities as to the accumulation of bile?
A. Absolutely.
Q. Do you think that ERCP is a dangerous examination?
A. I think there is some risk. The Scandinavian studies said people with a sphincterotomy have a 20 year risk of attaining bleeding problems, which is a long term risk for having that done.
Q. Would you advocate that we should use that in this setting?
A. In certain settings we can't, certain ones we

can, every patient is different.
Q. Is this a setting you think we should use them?
A. No, a bile leak that is controlled by a simple method, you don't have retained stones or injury to the common bile duct.
Q. You have no objection to the fact they did an ERCP on Mr. Diamond in Florida, do you?
A. No, I don't, but they used a different method than standardly is done. Literature at the present time an enodprosthesis, not a nasobiliary is a much better procedure, the stent should be longer.
Q. You don't have any criticisms of the care they rendered, correct?
A. No.
Q. I think that I asked the question, I'm not sure I got an answer, Rick will do the old asked and answered if I did, are you going to be rendering an opinion at trial as to why this cystic duct leaked at the time it did in October of 1995?
A. In Florida?
Q. Um-hum.
A. Most of the time this -- there is no exact science in biliary stuff.
MR. STRONG: I'm going to

object because there may be a list, he may not be able to pin down a specific reason within probability. I think he told you that he can't single one out.

Q. Just clarify something, probably a very large nonissue, do you have your copy of the report? On your second page you put, "A separate surgical reviewer stated that reoperation at the time the Jackson-Pratt catheter was drained would have been in the patient's best interest and I strongly disagree with this." I can only assume you are referring to Dr. Schlanger's report?

A. Absolutely.

Q. I want you to tell me where Dr. Schlanger stated a reoperation prior to ERCP.

A. Outlined in his deposition I just recently read.

Q. Didn't he indicate what he meant was he should have had an ERCP if they are going to bother having him under general anesthesia?

A. I think it's not clear.

MR. HERBERT: I object to that.

MISS KOLIS: I'm asking what he thinks it said.

MR. HERBERT: If you are trying to characterize what he said in deposition, I object to that.

Q. Let's take the report. What you had at the time you wrote this report, show me where you think he said reoperation without an ERCP. Can you read it, that's my original copy, sorry.

A. "The problem with this case is if Dr. Saxbe bothered to take the patient "-- this is Dr. Saxbe saying this?

Q. Dr. Schlanger saying this.

A. -- "take the patient for a general anesthesia, the patient syhould have been fully explored. Therefore, the patient would have been opened, the right upper quadrant observed, the leak would have been identified once the cystic duct was found."

In my opinion I disagree with this strongly. This is what I disagree with strongly for two reasons. At this point in time it would be a reoperation at the point of maximum adhesions, the worse time is between the 7 and 14 day mark. The worst time to find the cystic duct and tie off the cystic duct, it would have been impossible. I don't understand how anybody can do what he said in

his deposition.

To re-explore somebody if you are going to attempt to tie off the cystic duct, you definitely need an ERCP. Without an ERCP to do anything but place a drain in my opinion would have been wrong.

Q. I was asking you how you interpret that from his report.

A. That is what I interpret from that. Am I making myself clear? If you ask why I wrote this sentence here, you have it highlighted, without an ERCP you can't do re-exploration to tie the cystic duct as he said should have been done. Formal re-exploration in my opinion would have been wrong. You would risk injuring the common bile duct, giving life long problems.

Q. What do you understand he meant when he said the patient should have been fully explored?

A. I think he meant, and it came out more in his deposition, based on the fact I just read the deposition last night, he thought they should have re-explored and found the cystic duct and tied it. I think that would have been impossible to do.

Q. Do you understand when he says in the center therefore without the road map ERCP there was no

way to adequately treat this patient?
A. When I read that I could not understand exactly what he meant. I think drainage alone is a good way, accepted way.
Q. Obviously you are on record saying that.
Doctor, how were you recruited for reviewing this case?
MR. STRONG: Recruited?
Q. I guess that we will call it that.
MR. STRONG: If you know. She's asking how we first linked up with you, if you know.
A. I'm not sure. I'm not exactly sure. Obviously I'm back now in this area, my first deposition ever.
Q. In your whole life?
A. First deposition as a witness.
Q. As a medical expert?
A. Expert.
Q. Doctor, have you been sued?
A. No.
MISS KOLIS: Good for you. I don't have any further quetions.
MR. STRONG: We're going to have this printed, you can read it for accuracy.

In medical cases I prefer you read. We will have a week or so. It will be made available to you, if you see any terminology, anything you need to correct, you will have a sheet to do that on, you can sign off on it.

(Dr. Onders Deposition Exhibit A marked for identification.)

(Deposition concluded; signature not waived.)

ERRATA SHEET

NOTATION	PAGE/LINE

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

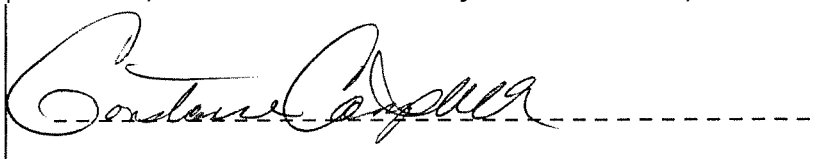
RAYMOND P. ONDERS, M.D.

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, RAYMOND P. ONDERS, 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 13th day of March, 1998.



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

Look-See Concordance Report

- - -

UNIQUE WORDS: **848**
TOTAL OCCURRENCES: 2,390
NOISE WORDS: 385
TOTAL WORDS IN FILE: 7,513

- - -

SINGLE FILE CONCORDANCE

- - -

CASE SENSITIVE

- - -

PHRASE WORD LIST(S):

- -

NOISE WORD LIST(S): NOISE.NOI

- -

COVER PAGES = **4**

- - -

INCLUDES ONLY TEXT **OF:**
QUESTIONS
ANSWERS
COLLOQUY
PARENTHETICALS
EXHIBITS

- - -

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- - -

INCLUDES PURE NUMBERS

- -

POSSESSIVE FORMS ON

- - -

MAXIMUM TRACKED OCCURRENCE THRESHOLD: 50

- -

NUMBER OF WORDS SURPASSING OCCURRENCE THRESHOLD: **2**

- -

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ERRATA SHEET

NOTATION	PAGE/LINE
20 year risk of secondary stone problems	39 - 21
stent should be left in longer	40 - 12

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

RAYMOND P. ONDERS, M.D.

GLEN T. DIAMOND V. DR. WILLIAM SAXBE AND THE OBERLIN CLINIC

On review of the case of Glen T. Diamond v. the Oberlin Clinic, records reviewed include:

Medical records from Allen Memorial Hospital 09/18/95 to 9/26/95
Medical records from Allen Memorial Hospital 09/11/95 - 9/12/95
Medical records from 6/13/95, 5/10/93
Medical records from North Florida Regional Medical Center admission from 10/05/95
Depositions
X-rays from North Florida

In summary, Mr. Diamond underwent an uneventful laparoscopic cholecystectomy on 09/11/95. The operation itself from the report went smoothly. There seemed to be no noted complications during the case. The patient was readmitted on September 18th for increasing generalized abdominal pain and a slightly elevated white count. After observing in the hospital, Dr. Saxbe felt that the patient had a bile leak from his recent laparoscopic cholecystectomy and he placed a Jackson Pratt drain in the right subcostal area in a bile collection. Patient was subsequently discharged from the hospital and in an out patient office visit, after noticing that there was no further drainage and the drainage was very non-bilious in presentation, the catheter was removed. The patient subsequently traveled to Florida and at that point was readmitted with severe abdominal pain to the North Florida Regional Medical Center. While there, they again placed another catheter to drain the bile under CT guidance. They continued to observe and noticed that there was an increasing amount of fluid around the liver and an ERCP was subsequently done. The ERCP showed that there were no injuries to the common bile duct, the right or left hepatic duct and it was purely a leak from the cystic duct. A stent was placed at that time and subsequently a re-evaluation of the biliary tract showed that there was no persistent leak from the cystic duct stent and resolution of his problem had occurred.

With this brief review of the records, the major concern is whether or not Dr. Saxbe had performed under the standards of care for laparoscopic cholecystectomy in the post-operative period. The important point is that when the patient presented with pain he was admitted to the hospital and observed. When he did not improve, the appropriate diagnostic tests, including ultrasound were performed and the correct assumption that this was a minor cystic duct leak was assessed by Dr. Saxbe. Many cystic duct leaks even from the open cholecystectomy era can be treated purely with drainage as long as there is no distal obstruction. This was attempted with the catheter and it appeared that it had worked with no further drainage and subsequently the Jackson Pratt was removed. Unfortunately for the patient, he had a recurrence of the cystic duct stump draining and had to undergo a repeat placement of the catheter at another hospital.

DEPOSITION EXHIBIT
3-10-98
A DR. ONDERS

The hospital in Florida did the exact same thing that Dr. Saxbe initially did which was to place a drainage catheter. They performed this under CT guidance as opposed to in the operating like Dr. Saxbe had performed. When they did not have improvement with their catheters, they underwent the ERCP with stent placement which had been proven in the recent years to be an excellent way to treat this cystic duct leaks. A cystic duct leak is the lowest grade of biliary tract problems after laparoscopic cholecystectomy. The long term implications for cystic duct leak is minimal. There was no evidence on the ERCP that the common bile duct, right or left hepatic duct were injured, which is the usual concern when you have a bile leak after a laparoscopic cholecystectomy. Dr. Saxbe correctly inferred that it was probably a cystic duct leak and treated it in a standard fashion of drainage. When the drainage technique alone does not work then an ERCP with stenting is the usual course of action. Many times many people recommend an initial ERCP for the diagnosis of any biliary leak which does work well, fortunately in this case the patient did not need that because he had the typical cystic duct leak. Obviously if the patient had a different injury, a Jackson Pratt drainage technique that Dr. Saxbe performed would not have been adequate, but in lieu of what the final findings was, his treatment was completely correct.

A separate surgical reviewer stated that a reoperaton at the time that the Jackson Pratt catheter was drained would have been in the patient's best interest and I strongly disagree with this. Without an ERCP any reexploration would have been extremely dangerous. It would have been to the patient's detriment. If reexploration would have been performed and an ERCP had not been done that would not have been in the standard of care therefore placing a drainage catheter by any technique, be it in the operating room through a small incision or through CT guided radiological procedure, is correct when there is fluid around the liver. Reexploring after a laparoscopic cholecystectomy injury without the road map of an ERCP would itot be in the standard of care and fortunately Dr. Saxbe did not do this. Over the last several years, as laparoscopic cholecystectomy become much more common around the United States, it is much more frequent to undergo an ERCP early in the course as opposed to initially draining it. In 1995 this was not common around the country. ERCPs are not without risks depending on how adept your gastroenterologists are at ERCP. There can be more risks with the ERCP than with just drainage alone. It is recommended that if somebody is doing ERCPs they should do approximately 100 per year. I am not sure what the situation is at Oberlin Clinic but if an gastroenterologist does not perform that many, it may not be in the patient's best interest to do an ERCP prior to taking care of the bile leak. This patient's ERCP was quite difficult from the note in North Florida where they actually had some bleeding problems at the time of ERCP which taken care of at the ERCP.

Again, in conclusion this patient had an unfortunate problem of a cystic duct leak which is a known risk from laparoscopic cholecystectomy. Of any problems that can happen after a laparoscopic cholecystectomy, this one has the least amount of morbidity. It can many times be treated just as Dr. Saxbe did with a drainage catheter. Many times it requires close monitoring with ERCP and stents and in this case this eventually occurred. In my opinion, the post operative management of this patient was done correctly and judiciously by Dr. Saxbe.

Sincerely,

Raymond P. Onders, M.D.
Director, Minimally Invasive Surgery
University Hospitals of Cleveland

RPO/jr

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In summary, Mr Diamond underwent **an** uneventful laparoscopic cholecystectomy on 09/11/95. The operation itself from the report went smoothly. There seemed to be **no** noted complications during the case. The patient was **readmitted** on September 18th for increasing generalized abdominal **pain** and a slightly **elevated** white count. After observing in the hospital, Dr. **Saxbe** felt that the patient **had** a bile leak from his recent laparoscopic cholecystectomy and he placed a Jackson Pratt drain in the right subcostal area in a bile collection. Patient was subsequently discharged from the hospital **and** in an out patient office **visit,** after noticing that there **was** no further drainage **and** the drainage was very non-bilious in presentation, the catheter was removed. The patient subsequently traveled to **Florida** and at that point was readmitted wirh severe **abdominal pain** to the North Florida Regional Medical Center While there, they again placed another catheter to **drain** the bile under CT guidance. They continued to ubserve and noticed that there **was an** increasing amount **of fluid** around the liver and an ERCP was subsequently done **The** ERCP showed **that** there were no injuries to the common bile duct, the right or left hepatic duct and it **was purely a** leak from the cystic duck. **A** stent was placed at that time and subsequently a re-evaluation of the biliary tract **showed** that there was no persistent leak from the cysric duct stent **and** resolution of his problem **had** occurred.

With this brief review of the records, the major concern is whether or not Dr. **Saxbe had performed** under the **standards** of care for laparoscopic cholecystecromy in the post-operative **period.** The important point **is** that when the patient presented with **pain** he was admitted to the hospital and observed When he **did** not improve, the **appropriate** diagnostic tests, including ultrasound were performed and the correct assumption that this **was** a minor cystic duct *leak* **was** assessed **by** Dr. **Saxbe.** Many cysric duct **leaks** even from the open cholecystectomy **era** can be treated **purely with** drainage as long **as** there is no distal obstruction. This **was** attempted with **the** catheter and it appeared that it **had** worked wirh **no** further drainage and subsequently the **Jackson** Pratt was removed. Unfortunately for the patient, he had a recurrence of the cystic **duct stump** draining **and** had to undergo a repeat placement of the catheter at another hospital.

FROM ROETZELBANDRESS (WED) 03. 25' 98 15:58/ST. 15:57/NO. 3560016402 P 2

The hospital in **Florida did** the exact same thing that Dr. **Saxbe** initially did which was to place **a** drainage catheter. **They performed** this under **CT** guidance **as opposed** to in the operating like Dr. **Saxbe** had performed. **When** they did not have improvement ***with*** their catheters, ***they*** underwent the **ERCP** with stent placement which **had been** proven in the recent **years to** be an excellent way to treat this cystic duct leaks. **A** cystic duct leak is the lowest grade of biliary *tract* problems **after** laparoscopic cholecystecromy. The long term implications for cystic; duct: leak is minimal. There **was no** evidence on the **ERCP** that the common bile duct, right or left hepatic duct were injured, which **is** the usual concern when you **have** a bile leak after a laparoscopic cholecystectomy. Dr. **Saxbe** correctly inferred ***that*** it **was** probably a cystic duct leak and treated it in **a** standard fashion of drainage. When the ***drainage*** technique alone does not work then an ERCP with stenting **is** the usual course of action. Many times **many** people recommend **an** initial **ERCP** for the diagnosis of any biliary leak which does **work** well, **fortunately in** this case the **patient** did nor need that **because** he **had** the **typical** cysric **duct** *leak.* Obviously if the patient **had** a different injury, **a** Jackson Pratt drainage technique that Dr. Saxbe performed would not **have** been adequate, but in lieu of what the final findings **was,** his treatment was complerely correct.

A separate surgical reviewer stated that *a* reoperaton at the t h e **that** the Jackson Pratt catheter was drained **would** have been in the patient's best interest and **I** strongly disagree with this. Without an ERCP **any** reexploration would have been extremely dangerous. It would have been to *the* **patient's** detriment. If reexploration **would have** been performed and an ERCP had not been done that **would** not have been in the **standard** of care therefore placing a drainage catheter by **any** technique. be it in the operating room through a small incision or through CT guided radiological procedure, is correct when there is **fluid** around the liver. Reexploring after a laparoscopic cholecystectomy injury without the road map of **an** ERCP would not be in the standard of care and fortunately Dr. Saxbe did **nor** ***do*** this. **Over** the last several years, as laparoscopic cholecystectomy become much more common around the United Stares, it is much more frequent to undergo **an** ERCP early in the course as **opposed to** initially **.draining** it. In 1995 *this* was not common around the country. ERCPs are not without risks depending ***OR*** how adept your gastroenterologists are **at** ERCP. There **can** be more risks with the ERCP than with **just** drainage alone. It is recommended that if somebody **is doing** ERCPs they should do approximately 100 per year. **I** am nor **me** what the situation is at Oberlin Clinic but if **an** gastroenterologist *does* not **perform** that many, it may not be in the patient's best interest to **do** an ERCP prior to taking *care* of the bile leak. This patient's ERCP was quite difficult from the note in North Florida where they actually **had** some bleeding problems at the time of ERCP **which** taken care of at the ERCP.

FROM ROETZEL&ANDRESS
(WED) 03. 25' 98 15:58/ST. 15:57/NO. 3560016402 P 3

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Sincerely,

Raymond P. Onders, M.D.
Director, Minimally Invasive Surgery
University Hospitals of Cleveland

RPO/jr

FROM ROETZEL&ANDRESS (WED) 03. 25' 98 15:59/ST. 15:57/NO. 3560016402 P 4

CURRICULUM VITAE

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Residency Review Committee 1990-1993

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Air Force Health Professions Scholarship

Undergraduate Education:
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Bachelor of Science
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Summa Cum Laude
Varsity Track and Field

MILITARY SERVICE:

United States Air Force Active Duty 1993-1997
Promoted to Major in 1994
Military Assignments while on Active Duty
Wright-Patterson Air Force Base, Ohio, 1996-1997
Grand Forks Air Force Base, North Dakota, 1993-1996
Military Highlights
Air Force Commendation Medal- Awarded 5/15/97
Meritorious Service Medal- Awarded 7/11/96
Combat Medical Readiness Training- 9/96
Chemical Warfare- 12/95
Officership Course- 7/95 to 9/95
Military Indoctrination for Medical Officers- 7/93
School of Aerospace Medicine- 8/85
Health Professional Officer Indoctrination Course- 7/85
Commissioned in Inactive Reserves 3/8/84

LICENSURE AND CERTIFICATES:

American Board of Surgery # 39016 - awarded 2/15/94
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Director of Minimally Invasive Surgery
Quality Assurance Committee Member

Wright-Patterson Medical Center/74th Medical Group 1996-97
Wright-Patterson Air Force Base, Ohio 45433
Chief of Minimally Invasive General Surgery
Director of General Surgery Quality Assurance

319th Medical Group 1993-96
Grand Forks AFB, ND 58205
Chairman of Medical and Surgical Services Quality Assurance 1996
Executive Committee of the Medical Staff 1995-1996
Chief of Surgical Services and Quality Assurance 1995
Chief of Surgical Clinic 1994-1996
Cancer Committee Chairman 1994-1996
Trauma Surgeon for 319th Air Transportable Hospital 1993-1996
Disaster Team Chief 319th Medical Group 1995-1996
Director of Anesthesia Services 1994-1996
Pharmacy Committee Member 1993-1994

Veteran Administration Medical Center 1993-1996
Fargo, ND

ACADEMIC APPOINTMENTS:

Case Western Reserve University
Assistant Professor of Surgery 1997-98

Uniformed Services University of the Health Sciences
F. Edward Hebert School of Medicine
Clinical Assistant Professor of Surgery 1997

Wright State University School of Medicine
Clinical Assistant Professor of Surgery 1997

University of North Dakota School of Medicine
Clinical Assistant Professor of Surgery 1994-1996
Clinical Instructor of Surgery 1993-1994
Residency Review Committee Member 1994-1996

PROE'ESSIONAL SOCIETIES:

Fellow of the American College of Surgeons 1992-1998
Society of American Gastrointestinal Endoscopic Surgeons 1995-1998
American Society for Gastrointestinal Endoscopy 1995-1998
Midwest Surgical Association 1996-1998

Society of Laparoendoscopic Surgeons 1995-1998
Society of Air Force Clinical Surgeons 1994-1997
Clinical Surgeons Award Committee Member 1997
Alpha Omega Alpha Honor Medical Society 1987-1998
North Dakota Chapter of the American College of Surgeons 1993-1996
American Medical Association 1988-1994

BIBLIOGRAPHY:

Onders RP, Stellato TA. Therapeutic Choledochoscopy and Its Complications. IN: Scott-Conner CEH, editors. The SAGES Manual: Fundamentals of Laparoscopy and GI Endoscopy. New York: Springer-Verlog: scheduled for release Fall of 1998.

Onders RP. Detection Methods of Helicobacter Pylori: Accuracy and Costs. American Surgeon 1997;63:665-668.

Onders RP. Book Review: Operative Laparoscopy and Thoracoscopy. Gastrointestinal Endoscopy 1997;45:448-449.

Onders RP. Utility of Office-Based Ultrasonography. Surg Endosc 11:209, 1997. (Abstract)

Clark JG, Onders RP, Knudson JD. Laparoscopic Distal Pancreatectomy Procedures in a Rural Hospital. AORN Journal 1997;65:334-43.

Onders RP. Maintaining Trauma Surgical Skills at Grand Forks Air Force Base. The Society of Air Force Clinical Surgeons Abstract Book, 1996.

Onders RP. Helicobacter Pylori Detection Methods at Grand Forks Air Force Base. The Society of Air Force Clinical Surgeons Abstract Book, 1996.

Onders RP. Detection Methods of *Helicobacter pylori* at a Rural Air Force Hospital: Accuracy and Costs. Surg Endosc 10:251, 1996. (Abstract)

Onders RP. Laparoscopic Distal Pancreatectomy Preserving the Spleen: Report of Two Cases. Surg Endosc 10:252, 1996. (Abstract)

Onders RP. Laparoscopic Distal Pancreatectomy of a Cystadenoma. Society of Laparoendoscopic Surgeons Vol. 4, 1995. (Abstract)

Onders RP. Laparoscopic Distal Pancreatectomy for a Cystadenoma. The Society of Air Force Clinical Surgeons Abstract Book, 1995.

Onders RP. Laparoscopic Appendectomies Decrease Inpatient Stay When Compared to Open Appendectomies. The Society of Air Force Clinical Surgeons Abstract Book, 1995.

Onders RP, Shenk RP, Stellato TA. Long-Term Central Venous Access: Size of Catheter and Site of Placement Increase Technical Problems. 61st Annual Scientific Meeting of Southeastern Surgical Congress Program Book, 1993. (Abstract),

Epner SL, Onders R, Burt N, Chung JB. The Socialization into the American Mental Health Belief System. *Ohio Journal of Science* 1985;85:57.

ACADEMIC PRESENTATIONS:

"Utility of Laparoscopy in Evaluating and Treating Lymphomas." To be presented at **Society of American Gastrointestinal Endoscopic Surgeons** Meeting Scientific Session, Seattle, April 2, 1998.

"Laparoscopic Surgery and Oncology in 1998." Presentation and part of faculty at Lymphoma Symposium at Aultman Cancer Center, Canton, Ohio February 19, 1998.

"Advances in Laparoscopic Gastrointestinal Surgery." Presented at Department of OB/GYN Grand Rounds at University MacDonald Womens Hospital on January 22, 1998.

"New Developments in Laparoscopic Surgery." Presented at University Suburban Health Center, January 6, 1998.

"Extraperitoneal Laparoscopic Hernia Course." Course Director, Westlake, December 12, 1997.

"Utlity of Office Based Ultrasonography." Presented at the Sixth International Meeting of Laparoendoscopic Surgeons, Orlando, Florida, December 5, 1997.

"Common Bile Duct Stones." Panel Discussion at Case Western Reserve University Surgical Grand Rounds, November 15, 1997.

"Advanced Laparoscopic Management of Peptic Ulcer Disease." Presented at Medical Surgical Conference October 21 and 28, 1997.

"Status of Minimally Invasive Surgery at University Hospitals." Presented to Executive Staff of University Hospitals, October 22, 1997.

"Update in Advanced Laparoscopy." Presented at Operating Room Nurses Grand Rounds at University Hospitals, October 22, 1997.

"Laparoscopic Surgery 1997: An Update." Workshop Session at **Clinical Update in Gastroenterology** at Forum Conference and Education Center, Cleveland, Ohio, September 20, 1997.

"Can a Surgeon be an Ultrasonographer? Does it involve Physics?" Case Western Reserve Surgical Grand Rounds, September 13, 1997.

"Advances in Laproscopic Surgery." Presented at UHHS Bedford Medical Center CME Program, Chagrin Valley Country Club, September 10, 1997.

"Newest Procedures to Treat Hernias." Presented at University Hospitals Health Series on September 16 and November 12, 1997.

"Heartburn? Is Laparoscopic Surgery The Answer?" Presented at University Hospitals Health Series on September 22 and October 21, 1997.

"Update in Advanced Laparoscopy." Presented at Grand Rounds at Barberton Hospital, June 21, 1997

"Office Ultrasounds in the Air Force." Presented at Scientific Session of the 44th Annual Symposium of the **Society of Air Force Clinical Surgeons** in California, April 16, 1997.

"Advances in Minimally Invasive Surgery." Pathology Grand Rounds at Wright Patterson Medical Center, Dayton, Ohio, April 14, 1997.

"Utility of Office-Based Ultrasonography." Poster presentation at 1997 SAGES Annual Scientific Session in San Diego, March 21, 1997.

"Trauma Ultrasonography: Maintaining Military Readiness." Director of course held at Wright Patterson Medical Center, February 19, 1997.

"Ultrasound Physics." Presented at Ultrasound Course held at the 74th Medical Group, Dayton, February 19, 1997.

"Breast Ultrasound." Presented at Ultrasound Course held at the 74th Medical Group, Dayton, February 19, 1997.

"Intraoperative Ultrasound." Presented at Ultrasound Course held at the 74th Medical Group, Dayton, February 19, 1997.

"The Effect of Advanced Laparoscopy on the types of Medical Referrals'' Grand Rounds to the Department of Internal Medicine at Wright Patterson Medical Center and Wright State University School of Medicine, February 14, 1997.

"Laparoscopic versus Open Appendectomy in a Rural Hospital: Outcomes and Costs." Presented at the Society of Laparoendoscopic Surgeons 5th Annual Endo Expo in Orlando. December 6, 1996.

"Detection Methods of Helicobacter Pylori: Accuracy and Costs." Presented at the 39th Annual Meeting of the Midwest Surgical Association at Mackinac Island, Michigan. August 20, 1996.

"Results of Laparoscopic Surgery for Pancreatic Disorders." Presented at the North Dakota Chapter of the American College of Surgeons in Minot, North Dakota. May 2, 1996.

"Maintaining Trauma Surgical Skills at Grand Forks Air Force Base." Presented at Critical Care/Trauma Symposium during the 43rd Annual Symposium of The Society of Air Force Clinical Surgeons in San Antonio, Texas. April 4, 1996.

"Helicobacter Pylori Detection Methods at Grand Forks Air Force Base." Presented at Scientific Session during the 43rd Annual Symposium of The Society of Air Force Clinical Surgeons in San Antonio, Texas. April 2, 1996.

"Detection Methods of Helicobacter Pylori at a Rural Air Force Hospital: Accuracy and Costs." Presented at the 5th World Congress of Endoscopic Surgery and SAGES Scientific Session in Philadelphia, Pennsylvania. March 13-17, 1996.

"Laparoscopic Distal Pancreatectomy Preserving the Spleen: Report of Two Cases,'' Poster presentation at the 5th World Congress of Endoscopic Surgery and **SAGES** Scientific Session in Philadelphia, Pennsylvania. March 13-17, 1996.

"Helicobacter Pylori Management Controversies." Presented at MetroHealth Medical Center, Cleveland, Ohio. February 15, 1996.

"Helicobacter Pylori Detection Methods and The Changing Indications for Ulcer Surgery." Presented at General Surgery Grand Rounds at the University of North Dakota School of Medicine, United Hospital, North Dakota. January 19, 1996

"Laparoscopic Distal Pancreatectomy of a Cystadenoma." Presented at the Society of Laparoendoscopic Surgeons Endo Expo 95 in Orlando, Florida. December 8, 1995.

"Laparoscopic Distal Pancreatectomies." Presented at MetroHealth Medical Center, Cleveland, Ohio. August 17, 1995

"Laparoscopic Appendectomies in North Dakota." Presented at MetroHealth Medical Center, Cleveland, Ohio. August 17, 1995.

"Advanced Laparoscopic Techniques." Presented at University of North Dakota Surgical Grand Rounds at United Hospital, Grand Forks, North Dakota. May 19, 1995.

"Laparoscopic versus Open Appendectomy: Outcomes and Costs." Presented at the United Hospital, Grand Forks, North Dakota. May 19, 1995.

"Laparoscopic Distal Pancreatectomy for a Cystadenoma." Presented at the 42nd Annual Symposium of The Society of Air Force Clinical Surgeons, Dayton, Ohio. April 25, 1995.

"Laparoscopic Appendectomies Decrease Inpatient Stay When Compared to Open Appendectomies." Presented at the 42nd Annual Symposium of The Society of Air Force Clinical Surgeons, Dayton, Ohio. April 26, 1995.

"Wound Ballistics." Presented to the 319th Medical Group, Grand Forks, North Dakota. November 17, 1994.

"Parathyroid Cancer: An Update." Presented at Surgical Grand Rounds University of North Dakota School of Medicine. November 4, 1994.

"Retention Sutures in General Surgery." Presented at Surgical Grand Rounds University of North Dakota School of Medicine. November 4, 1994.

"Wound Management." Presented to the 319th Medical Group, Grand Forks, North Dakota. October 7, 1993.

"Long-Term Central Venous Access: Size of Catheter and Site of Placement Increase Technical Problems." Poster Presentation at the 61st Annual Scientific Meeting of Southeastern Surgical Congress at Tarpon Springs, Florida. February 8-11, 1993.

"Parathyroid Cancer: A Case Report and Review of The Literature." Presented at Surgical Grand Rounds MetroHealth Medical Center, Cleveland, Ohio. April 3, 1993.

"Retention Sutures: The Facts." Presented at Surgical Grand Rounds MetroHealth Medical Center, Cleveland, Ohio. April 3, 1993.

"Long-Term Central Venous Access: Size of Catheter and Site of Placement Increase Technical Problems." Presented at MetroHealth Medical Center Scientific Contest for Residents and Fellows, Cleveland, Ohio. May 28, 1992.

"Operative Experience of Case Western Reserve Integrated Hospitals with Long Term Central Venous Access." Presented at Surgical Grand Rounds University Hospitals, Cleveland, Ohio. March 21, 1992.

"Jejunoileal Atresia." Presented at Pediatric Surgical Grand Rounds at Rainbow Babies and Children's Hospital, Cleveland, Ohio. January 25, 1992.

MANUSCRIPT REVIEWER:

Federal Practitioner
Gastrointestinal Endoscopy

OTHER ACTIVITIES:

Developed a center for advanced laparoscopic surgery at Wright-Patterson Medical Center including ways to limit the costs at our center.

Functioned as a trauma fellow at MetroHealth Medical Center from 8/2/94 to 9/23/94 to stay current in the management of trauma for the United States Air Force.

Underwent burn management and burn surgery update at MetroHealth Medical Center Burn Center from 8/5/95 to 8/20/95 to maintain skills for United States Air Force.

REFERENCES:

Jerry M. Shuck, M.D., Professor and Chairperson, Case Western Reserve University, University Hospitals of Cleveland, 2074 Abington Road, Cleveland, Ohio 44106-5000, (216) 844-3871

Thomas A. Stellato, M.D., Professor of Surgery, Chief, Division of General Surgery, University Hospitals of Cleveland, 11100 Euclid Avenue, clevleand, Ohio 44106-5047

James Durning, M.D., Colonel, USAF, Chief of Surgical Flight, 74th Medical Group/ SGOSG, Wright-Patterson Air Force Base, Ohio 45433, (513) 257-9922

David R. Antonenko, M.D., Ph.D., Professor and Chairman Department of Surgery, University of North Dakota School of Medicine, P.O. Box 9037, Grand Forks, ND 58202-9037 (701) 777-3067

Mark O. Jenson, M.D., Chief, Surgical Services, VA Medical Center, 2101 N. Elm Street Fargo, ND 58201, (701) 232-3241

4-335 DIAMOND: DEPO INDEX OF RAYMOND P. ONDERS, M.D.
Taken Tuesday, March 10, 1998

PAGE/LINE

5/06 Doesn't know when he wrote the report

5/15 Report marked Exhibit A

5/18 It's the only report

5/22--6/9 Reviewed medical records, Saxbe and Diamond's depositions, as well as the Florida KUB, abdominal x-rays, and ERCP

6/18 The KUB and ERCP did not form the basis of his opinions

7/15 Boarded in general surgery in 1994

8/01 Since 1988, was in the U.S. Air Force for 4 years prior to coming back as Director of Minimally Invasive Surgery at Wright Patterson

8/14 Minimally invasive surgery includes advanced laparoscopy, credentialing in new providers, in charge of quality assurance for laparoscopic procedures

4/01 Advanced laparoscopies are splenectomy, pancreatectomy, liver resection

9/17 In the Air Force, was Director of Quality Assurance. At the hospital there is a quality assurance group

9/20 As part of Quality Assurance, evaluates physicians and proctoring

10/03 Quality Assurance is peer review committee

10/13 Quality assurance is trying to make sure the patient gets good quality care

10/21 Q.A. is to help a physician do a procedure in the most expeditious and beneficial way

11/03 Mr. Diamond's leak was a cystic duct leak

11/07 Which is a known and common complication

11/17 Where and when ERCP has been available is different based on different areas of the United States

11/24--12/5 ERCP was first introduced in the 1980s in major centers

(4-335 DIAMOND: DR. ONDERS' DEPO INDEX)

12/07 The purpose of ERCP is to identify leaks of the common bile duct, look for tumors and obstructive jaundice

12/12 ERCP was not common in the late 80s or early 90s. There are still areas where ERCP can't be performed

12/17 Gastroenterologists in most areas are required to have specialized training

12/25--13/ Dr. Onders did not do ERCPs

13/02 They are generally done by gastroenterologists. Some surgeons do it but it requires further training

13/06 Has not spoken to Saxbe

14/05 ERCP is not used to drain a collection of bile

14/07 ERCP is a diagnostic tool to determine the cause of a bile leak and Dr. Onders would not have used it in 1995 to diagnose

14/12 Where he was stationed in North Dakota, there was no gastro and it was more to the patient's detriment to have an ERCP

14/19 "The other aspect is that data shows us you don't need an ERCP"

14/25--15/3 Reference to an article regarding outcomes with drainage alone

15/4-10 Drainage by either Jackson-Pratt or a catheter placed via ultrasound

15/11-20 It is not common or cost effective to repeat an ultrasound to determine if the drain has cleared a collection

15/21 Not sure of the cost of a sonogram to confirm that the collection has been cleared

16/01 Estimates $500 - 600

16/15 Most patients with a closed suction drain he would not do a follow-up study. Only remove it when the drainage stops

16/20 When Diamond was released from Allen Memoria;, be was Still draining fluid to less than an ounce a day

17/01-- This is consistent with Saxbe's notes

(4-335 DIAMOND: DR. ONDERS' DEPO INDEX)

17/08 It was serous in nature, not bilious

17/11 Does not believe it is the standard of care to do a follow-up test to make sure that the bile has resolved

17/16 Hospital has no standards regarding discharge of patients with bile leaks

17/24--18/4 Finds it remarkable that Schlanqer has not seen a situation like this where ERCP was not used

18/02 Published study showed 25% of patients did not have any diagnostic studies such as an ERCP

18/06 Relying on Surgical Endoscopy, 1996

18/21 Didn't rely on anything specifically for his opinions in this case regarding articles

19/6-19 Causes of cystic duct leaks are multifactorial. Cystic duct leaks are common, caused by the clip being dislodged and the back-up pressure

19/20 Does not have an opinion as to the cause of the cystic duct leak in this case

20/02 The most likely cause is the clip doesn't completely control the cystic duct

20/17 No specific treatment for cystic duct leak. No 100% way to treat it. A multitude of different ways to treat

20/22 The common case as the standard is to drain it

21/01 The goal with drainage is control fluid accumulation and fistula

21/08 The leak will heal if you lower the pressure, Bile goes to the duodenum

21/16 Scar formation is the reason why drainage is many times the best way to treat

21/19 In this case, there is no injury to the common bile duct

21/23--22/6 Determination that adequate scar formation has occurred is based purely on the drain output, when the drainage no longer looks like it contains bile

22/10-18 15% of people post-lap-chole have a fluid collection

22/19 If you have a fluid collection and you are draining bile appropriately, a fluid collection is not a problem

23/02 When the patient is symptomatic, he can have a problem with bile collection

23/10 Sonogram and CAT scan are equally acceptable for evaluation of fluid accumulation

23/20--24/3 When the patient gets better enough to go home, that is what we go by (in terms of whether there is an additional collection)

24/06 Getting better means discharged from the hospital, eating normally, ileus resolved, labs normal

24/09 The ileus is related to the bile leak

24/19 Whenever a drain is placed, peritoneal fluid will come from the cavity

24/21--25/2 The drain is left in to be sure the patient is doing well

25/12 Based on the notes and the fact that the drainage was no longer bile-tinged and less than one ounce, patient doing well, I would remove the drain

25/17 No one can know whether there was adequate scar formation to prevent a bile leak at the time of discharge

25/23 But based on the clinical information, would assume the scar tissue is good. There is no criterion the scar tissue is good

25/25--26/2 His presentation was late in the course. There should have been scar tissue. He shouldn't have had a leak to begin with

26/03 He was re-hospitalized because he re-leaked from the cystic duct

26/08 Initially, the leak was controlled and for some reason, he began to re-leak again

26/21 "I think the leak stopped leaking, then, for whatever reason? it started leaking again"

27/1-7 By all criterion available, he had stopped leaking

27/09 It was a very late leak to begin with, which is very uncommon

28/09 Most cystic duct leaks would occur from soon after presentation to within days

(4-335 DIAMOND: DR. ONDERS' DEPO INDEX)

28/71-18	The fluid, shown on sonogram, in 15% of people is not bile
28/21	5% of people leak bile after cholecystectomy
28/24	Probably from the cystic duct
29/02	Slow leaks tend to be symptomatic as much as large leaks
29/04	No medical opinion for the cause of the late leak
29/07	One cause for a late leak would be secondary to a retained common bile duct stone. The liver function study showed that a retained stone was not the reason for the late leak
29/17	I have no idea why this (late leak) occurred?
29/20	There is noting authoritative on this. There are a lot of common different reasons
30/1-7 28	'There is always a possibility a cystic duct may recur. It's on our initial consent form
31/2-6 28	Advises his patients, after treating them for a cystic duct leak, that there is a possibility of it spontaneously reopening
31/18	The care given in Florida was initially the same as that given by Saxbe
32/18	In Florida, temperature was elevated, patient not doing well, drainage had stopped. They repeated the CAT scan
33/04	Elevation of temperature is an indication for a rescanning
33/11	Stenting decreases pressure to allow healing
33/14	A low pressure system allows the cystic duct walls to collapse, scar and close
33/18	This is the same result obtained by using a Jackson-Pratt Drainage
33/21	Stenting and drainage alone are equal in their efficacy
34/1-6	Not aware of whether there was a gastro at Allen Memorial who could do an ERCP.
34/18	If the patient is doing very well, would not subject them to the risk of ERCP

(4-335 DIAMOND: DR. ONDERS' DEPO INDEX)

35/05 A patient well enough to *go* home can be transferred

35/13 A patient that can be discharged home can be transferred to other hospitals

35/15 Whether he would consult with a gastro in a patient returning with a cystic duct leak depends on whether there is a gastro available

36/06 If the cystic duct leak is controlled with drain, he would not consult a gastro

36/13 If it was a cystic duct leak, Onders feels equipped as a surgeon to formulatn a plan of care

36/22 If **I** was unsure where the patient was leaking, I would think of obtaining an ERG1 and since I don't do ERCP, I would have consulted someone that does

37/1-6 We know it was a cystic duct leak but there was no confirmation of that in the initial hospitalization

37/08 This is a very common inference. There is a risk to confirming where the leak is

37/21 "There was not confirmation this was a cystic duct leak"

39/02 After you place a drain and receive bile, it must be coming from the biliary system, the cystic duct leak, Duct of Luschka leak, anywhere from the entire biliary system

39/05 You cannot exclude there may have Seen an injury to the common bile duct, but the Liver enzymes were not elevated

39/9-13 Bile in a nasogastric tube indicates that there was not a complete obstruction

39/14 Therefore, there are other possibilities as to the accumulation of bile

39/17 ERCP involves some risk. Scandinavian studies, 20-year risk of obtaining bleeding problems

40/02 This is not a setting where you would use that. study since it is a bile leak controlled by simple method. You don't have retained stones or injury to the common bile duct