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IN THE COURT OF COMMON PLEAS
OF SUMMIT COUNTY, OHIO

VICKIE MIGLORE, et al,
Plaintiffs,
vs. Case No. 99CV030973
DAVID COLA, M.D., et al,
Defendants.

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Deposition of MEADE A. PERLMAN, M.D., called for examination under the statute, taken before me, Barbara J. Watowicz, a Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at the offices of Meade A. Perlman, M.D., 6046 Whipple Avenue, N.W., Canton, Ohio, on Wednesday, October 11, 2000 at 5:30 p.m.

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APPEARANCES:

On behalf of the Plaintiffs
Becker & Mishkind, by
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(216) 241-2600

On behalf of the Defendants
Buckingham, Doolittle
& Burroughs, by
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(Thereupon, Plaintiff's Deposition Exhibits 1 and 2 were marked for purposes of identification.)

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MEADE A. PERLMAN, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF MEADE A. PERLMAN, M.D.

BY MR. MISHKIND:

Q. State your name, please.

A. First name is Meade, M E A D E. Middle initial A for Andrew. Last name is Perlman, P E R L M A N.

Q. I'm going to show you what I have marked as Plaintiff's Deposition Exhibit 1. It is a two-page document. Is Exhibit 1 a copy of the report that you wrote in this case?

A. Yes.

Q. And is Exhibit 2 a copy of your current curriculum vitae?

A. Yes.

Q. Is it current and updated or are

there any additions that need to be made?

A. There are no additions.

Q. One other item I want to mark as an exhibit before we move into the questioning that I have, doctor. There is a, a chart that was included in the material that was provided to you by Mr. Frasure. Is this chart something that was provided to you or is this something that you made up?

A. No, that was provided to me.

Q. And did you rely upon this in any way as you studied this case?

A. No. The materials in this folder or this notebook came to me yesterday in the mail. I have not really read them in any detail. And so the answer is no. I wrote the report September 25th.

Q. Okay.

A. Okay.

MR. MISHKIND: All right. Let's go ahead and mark what I have referred to as Exhibit No. 3.

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(Thereupon, Plaintiff's Deposition Exhibit 3 was marked for purposes of

identification.)

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Q. Is Exhibit 3 a chart with various lab values that came to you since your report?

A. That came yesterday. I have not looked at it, so I don't know what the source of it is. I haven't done a crosscheck on it for reliability with the medical records.

Q. Fair enough. It was included in a three-ring binder, a one-inch binder that came to you yesterday along with other material that I'm about to identify, okay?

A. Sure.

Q. Included in this notebook are some office records from Leonard Torok. I take it you did not review those records previously or did you?

A. I did not review them before I wrote the report. I have seen the records since I wrote the report.

Q. Okay. Yet in your report you reference medical records of Dr. Torok, don't you?

A. Wait a second. Let's look here.

Okay. Then I did see those before

I wrote the report. That was in error. Yes.

Q. All right. Yet Dr. Torok's records which we have just started talking about a moment ago you had identified in this three-ring binder that you just received yesterday, true?

A. Right. There may be duplicates of those here in this pile. I don't know if there is or there isn't, but I did see Dr. Torok's records before I wrote the report. I don't see them right here. But I know that I looked at them. Whether Mr. Frasure showed me them at some point I obviously can't say.

MR. FRASURE: Let me see what you have there.

Q. Let me ask you to do me a favor. You have a tendency to start talking before I finish. Let's not talk at the same time because her evening will be more of a nightmare than it's already going to be, okay?

A. Yes, sir.

Q. The notebook that we're referring to, the three-ring binder, it says medical records of Vickie Miglore and it has a volume on it and it references Akron City, Cleveland

Clinic records as well as records of Dr. Jose Zarconi, true?

A. I guess so. I have not really read through them, but I assume that's what's in here.

Q. Okay. And again, the previously mentioned records of Dr. Torok with a nice cover page identifying them as records?

A. Yes.

Q. Okay. Now, in your report you have identified a number of items that you reviewed in preparation for your report dated September 25th. We've talked about Dr. Torok's records which you believe you saw?

A. I saw them in advance of writing the report.

Q. All right.

A. Yes.

Q. But they are not in the stack of material --

A. No.

Q. Let me finish, doctor, please.

A. I'm sorry.

Q. They are not in the stack of material that you have, that you have in front

of you that you identified as being the material that you had before the report, true?

A. Well, there may be other materials that I had before the report, and I didn't bring them along. And I know that I saw the report from Dr. Torok at Mr. Frasure's office at some point prior to writing the report.

Q. Okay.

A. And that may have been the point at which I saw them.

Q. Tell me what material you have reviewed that you didn't bring with you today.

A. I can't tell you that. As far as I know, these are all of the materials in my possession. These are all of the materials that I reviewed prior to writing the report. Did that answer your question?

Q. It did. And just to clarify, the only additional material that has arrived since the report are the items that I identified in the three-ring binder as well as this grid of lab values, true?

A. The only things that I have gotten in my possession, yes.

Q. Can you tell me what else you have

received but don't have in your possession -- let me finish -- you have received and don't have in your possession that arrived some time after preparing your report, but not before today or but before today, I should say?

A. At Mr. Frasure's office I have seen more extensive records of Mrs. Miglore from Akron City Hospital. I can recall that. I did not see those prior to writing the report. And I would have to look through here and I don't recall anything else. In other words, this is an abstract of I think more extensive record at Mr. Frasure's office.

Q. Those are the Akron City records that you are referring to?

A. Yes, correct. But I'm not aware of any other materials that I have seen that aren't referenced here.

Q. You reference in the first paragraph of your letter reports written by Hadley Morgenstern-Clarren, Thomas Sisic and another doctor. I didn't see those records in the materials.

A. They were at one point in time in my possession. Whether I left them back at

Mr. Frasure's office after conferring with him, I can't tell you. But I did have those physically in my possession.

Q. Is there anything else before I move on to substantive matters that is no longer in your possession that, that you have reviewed?

A. No. Everything that I have reviewed is listed here that was reviewed prior to writing the report. And these are the materials that I received after writing the report that were sent to my office and I have at a conference at Mr. Frasure's office seen more comprehensive records from Akron City Hospital.

Q. Okay. Your charge today for the deposition is $750, true?

A. Yes.

Q. What is that based upon?

A. That covers up to three hours of time in deposition.

Q. How many hours have you dedicated to your review in connection with this case to date?

A. About ten.

Q. Your report was written September 25. Can you tell me how long before the letter was prepared that you were retained in this case?

A. I was not retained. I was asked to review the records and agreed to do so. I suspect sometime in August.

Q. Are you able -- do you have any type of billing record that would reflect when you first put service in on the case?

A. Not precisely, no.

Q. When you said you weren't retained, you have been retained by Mr. Frasure as an expert in connection with this case?

A. Well, I don't know what you mean by retained. Maybe you would like to explain that.

Q. You just take issue with the use of the term?

A. Right. He asked if I would be willing to serve as an expert and I agreed.

Q. Okay. Tell me what a differential diagnosis is, doctor.

A. That's a term that is used by some people to reflect an attempt at enumerating

possible conditions that may explain underlying physical findings, symptoms, complaints, laboratory studies.

Q. Would you agree with this statement. That it's an exercise in sifting through signs and symptoms, physical findings and laboratory data and compiling a list of potential conditions that could cause one or more of the findings?

A. I would agree that it's an exercise with an emphasis on exercise.

Q. I'm going to ask my question again. Would you agree with this statement. That it is an exercise in sifting through signs and symptoms, physical findings and laboratory data and compiling a list of potential conditions that could cause one or more of the findings?

A. Yes.

Q. Okay. That is considered standard practice for an internist or a primary care doctor in evaluating a patient, correct?

A. No, sir.

Q. It's not?

A. No, sir.

Q. Tell me why you take issue with

that.

A. I'm not aware that it is. I mean that's something I'm not familiar with.

Q. Is a differential diagnosis something that you do on a day-to-day basis?

A. No.

Q. Do you arrive at a differential diagnosis when you are presented with a multitude of potential findings, signs and symptoms and laboratory data in an effort to arrive at a diagnosis in a patient?

A. Not under ordinary circumstances.

Q. Well, do you automatically conclude that a particular patient has a particular condition without considering potential diagnoses?

A. No.

Q. Is the term differential diagnosis something that you use in your world?

A. Not on a regular basis.

Q. You're an internist, correct?

A. Yes, sir.

Q. Board certified in internal medicine?

A. Yes.

Q. You recognize Harrison's as a reliable and authoritative text in the area of internal medicine, true?
A. No.
Q. What text do you own in the area of internal medicine?
A. I own no text in internal medicine.
Q. Okay. What journals do you subscribe to?
A. The Journal of the American Medical Association. The New England Journal of Medicine. The Lancet. The Annals of Internal Medicine. The Archives of Internal Medicine. The Mayo Clinic Proceedings. The Journal of American Geriatric Society. Those are the ones that come to mind immediately.
Q. You do not own Harrison's?
A. No.
Q. You don't own any textbooks relating to the area of internal medicine?
A. No.
MR. FRASURE: You include his clinic, too? Do you mean him personally or the office that he's with here?
MR. MISHKIND: Well, let's start

with him personally.
A. No.
Q. You have Harrison's available to you in the clinic, don't you?
A. No.
Q. You don't. Do you acknowledge that Harrison's is one of the leading textbooks in the area of internal medicine?
A. Yes.
Q. Okay.
A. In terms of popularity.
Q. It's just not one that you own or that you refer to from time to time, true?
A. In general circumstances that's correct.
Q. Have you done any research at all in the medical literature in connection with any aspects of the opinions that you hold in this case?
A. Yes.
Q. What have you researched?
A. I read the chapter on Wegner's granulomatosis in Scientific America Medicine.
Q. What else, if anything?
A. I attempted a Med Line search on

some aspects of Wegener's granulomatosis.

Q. You attempted it?

A. Well, I put in queries, but I didn't get any responses.

Q. You put in Wegner's granulomatosis in a Med Line?

A. Along with additional factors.

Q. What were the additional factors?

A. Hematuria.

Q. Okay. So you put in Wegener's granulomatosis and hematuria and you got no hits?

A. That's right.

Q. And this was a Med Line?

A. This was Med Line going back to 1995.

Q. What else did you do by way of research or reading in the medical literature?

A. I believe that's all.

Q. Did you find the information in Scientific America to be consistent with the opinions that you hold as it relates to Wegener's granulomatosis?

A. In general, yes. I wouldn't say everything that they mentioned was something

that I would necessarily concur with, but in general.

Q. You have been deposed in the past, true?

A. Yes.

Q. Tell me, just get me up-to-date, how many times in the past have you been deposed?

A. I'd have to give you an estimate of about between one and two dozen times.

Q. So between 12 and 24 occasions?

A. Roughly.

Q. Over the past year, let me try to deal with more recent. We're in, what are we now, October?

A. Yes.

Q. Let's say the last year or perhaps even year-and-a-half, whatever is easier for you, on how many occasions have you given deposition testimony?

A. I think in the past year probably five or six.

Q. Of the 12 to 24 times that you have given deposition testimony on how many occasions have you testified in deposition in

support of allegations made by a patient?
A. Once.
Q. And was that the Knuth case?
A. Yes.
Q. Okay. Plaintiff's counsel in that was Mr. Ockerman, true?
A. I think he was a co-counsel with an attorney in Phoenix.
Q. You review cases on what frequency per year?
A. That really varies according to how frequently I'm asked. Probably within the past year I have looked at six or eight which I would say is the most ever.
Q. Besides this case currently how many other cases are you serving as an expert for the Buckingham, Doolittle firm?
A. I can think of one other case.
Q. You have been doing medical/legal work for the last ten or 11 years?
A. I'd say 15 years or so.
Q. 15 years. The 12 to 24 cases or 12 to 24 times that you have been deposed, you have been serving as a standard of care expert providing testimony as to whether a particular

doctor in your opinion met or complied with the standard of care, true?

A. Among other issues, yes.

Q. And in those cases have essentially two-thirds of those times been for lawyers from the Buckingham, Doolittle firm?

MR. FRASURE: Of all cases he's reviewed to date?

MR. MISHKIND: In terms of testifying.

MR. FRASURE: Well, testifying, going to a deposition?

MR. MISHKIND: Right.

A. I think this time it's probably half or so.

Q. So the last five or six depositions that you have done in the last year or so have been for other firms other than Buckingham, Doolittle?

A. I'm trying to think if there have been any other for Buckingham, Doolittle.

MR. FRASURE: This year.

A. This year or within the past 12 months. There were attorneys with Buckingham, Doolittle who left and basically the

depositions I think were held after they left the firm. So I think that probably this is the first one to my recollection in the last 12 months.

Q. For a past and current Buckingham?

A. Then we're up over half.

MR. FRASURE: You can include those.

Q. For example, people like Mr. Shelbert?

A. Right.

Q. Did those constitute some of the five or six that you have done?

A. Yes, yes.

Q. If you take past and present people from Buckingham, Doolittle, is it still approximately two-thirds of your cases have emanated from the Buckingham, Doolittle roots?

A. I think it was still probably half. I would have to sit down and enumerate these. I don't want to be imprecise, but I have looked at them from a number of firms and have been deposed in the past year.

Q. You are not currently serving an expert in any plaintiffs' cases?

A. No.
Q. The only time you have testified in deposition as a plaintiff's expert was in the Knuth case?
A. Yes.
Q. Are you currently scheduled to give deposition testimony in any other cases in the foreseeable future?
A. No.
Q. When were you last deposed?
A. Let me think back. I think it was sometime in May. I'm trying to remember if there was one that took place over the summer. I recall an expert deposition in May.
Q. Who deposed you in May?
A. It was an attorney from either Cleveland or the far eastern suburbs. And I don't remember his name.
Q. What attorney were you retained by or some similar term?
A. This was from Reminger & Reminger, I believe. I think it was Ms. Sandacz and Ingrid Kinkopf-Zajac. If I'm remembering it correctly. It was a difficult hyphenated name. I think the two were working on the case

together.

Q. The name of the defendant doctor in this case?

A. Dr. Murphy.

Q. John Murphy?

A. Yes. Actually, there may have been another one over the summer, but I can't remember the name offhand. And that was from Roetzel & Andress. There was one that was more recent.

Q. Who was plaintiff's counsel?

A. Again, I don't recall. It's from a firm that's got an office in Canton and one all over the place. And I don't remember the firm's name.

Q. The name of the plaintiff or the defendant in that case?

A. The defendant's name is Stachel. S T A C H E L. That's still going on.

Q. Is he a Canton, Ohio doctor?

A. Yes.

MR. FRASURE: Howard, for clarification.

Are you reviewing a case now for Lee Bell for deposition?

THE WITNESS: That's been resolved. My deposition was not taken in that.

MR. FRASURE: That's been resolved.

Q. All right. And on how many occasions up-to-date have you been represented by Buckingham, Doolittle?

A. On two occasions.

Q. Are you sure?

A. Yes.

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

A. No.

Q. Have you ever talked to Dr. Cola?

A. No.

Q. Do you know Dr. Gary Hoffman from the Cleveland Clinic?

A. No.

Q. Dr. Zarconi, Vickie Miglore's nephrologist?

A. No.

Q. Dr. Schirack, Dr. Torok?

A. No.

Q. Dr. Spolarjic?

A. No.

Q. I omitted -- I failed to ask you on

how many occasions have you worked personally with Mr. Frasure? When I mean personally, I mean on how many occasions has he asked you to serve as an expert besides this case?

A. Perhaps three or four.

Q. How many times have you been named as a defendant in a medical negligence case?

MR. FRASURE: Objection.

Go ahead.

MR. MISHKIND: You can show a continuing line.

MR. FRASURE: Okay.

A. Three times.

Q. Are you currently a defendant?

A. No.

Q. I have the benefit of your report which starts out with a summary of some pertinent facts and then you ultimately make a concluding statement in the last paragraph that in your opinion Dr. Cola met the standard of care and his care did not contribute to her subsequent development of Wegener's or the rapidly growing glomerulonephritis?

A. True.

Q. Were you asked to opine or to

provide opinions with regard to the care provided by any other doctors along the continuum of Vickie Miglore's treatment?

A. No.

Q. Do you have any criticisms of any of the care provided by any of the doctors along the continuum?

A. I did not review the materials with an eye towards forming any criticisms, so I would have to go back and re-review them specifically to answer that. It was not what I was asked to do and I didn't do that.

Q. As you sit here right now as I take your discovery deposition, you have not formulated any opinions that would permit you to say that you hold an opinion that doctor A or doctor B or doctor C or doctor whomever breached the standard of care in the treatment of Vickie Miglore, is that correct?

A. Neither breached nor met the standard of care.

Q. So you have no opinions one way or another?

A. I have not attempted to formulate any.

Q. Okay.
A. I have not been asked to.
Q. Okay. Fair enough. That was not your assignment?
A. Right.
Q. Okay. Let's talk about Wegener's and talk about Vickie Miglore. First Wegener's. Do you have any Wegner's granulomatosis patients within your patient population?
A. Not alive.
Q. How long have you been in practice?
A. Since 1977.
Q. How many of your Wegner's patients have died?
A. One.
Q. How many Wegener's patients have you had?
A. One.
Q. How long ago was it that you had a Wegner's patient about?
A. Five years ago.
Q. Male, female?
A. Female.
Q. Age?

A. Approximately 65.
Q. Onset of Wegener's at what age?
A. Approximately 64.
Q. What organ system was first implicated?
A. Her lung.
Q. Did she develop renal failure?
A. What do you mean by renal failure?
Q. Did she develop kidney involvement secondary to Wegener's?
A. Yes.
Q. What was the affect on her kidneys? Did she go on to develop renal dysfunction?
A. She developed renal dysfunction on laboratory studies.
Q. Did she require dialysis?
A. No.
Q. What was her kidney function? How impaired?
A. I think her peak creatinine was about four.
Q. The major manifestation was upper and lower respiratory fracture?
A. Yes.
Q. And did she die of complications of

the Wegener's or complications of other medical conditions?

A. Complications of the Wegener's.

Q. Was her life expectancy in your opinion reduced secondary to the effects of the Wegener's?

A. Yes.

Q. Was she a patient that you diagnosed with Wegener's or did she come to you with a pre-established diagnosis?

A. I diagnosed with the assistance of others.

Q. Who did you call in?

A. I think a pulmonologist was involved.

Q. How long was it from the time that you recognized the symptoms until the time that you called in a pulmonologist?

A. I called in a pulmonologist about ten days to two weeks into her illness.

Q. What were her clinical signs and symptoms?

A. She had problems with cough. Progressive shortness of breath. Progressive abnormalities on a chest x-ray and fever which

led to respiratory failure.

Q. And on x-ray did you see the characteristic vasculitic changes?

A. She had abnormalities. I don't remember the exact pattern. I don't know whether there was a characteristic vasculitic change.

Q. Are you saying that there is or isn't?

A. I'm not aware that there is such a term.

Q. But when you speak of Wegener's granulomatosis you are speaking of a, of a condition that involves multi systems, correct? A disease that is multi-system?

A. Typically, yes.

Q. And it creates -- one of the indicia of Wegener's granulomatosis is vasculitic changes or vasculitis, correct?

A. Well, there are necrotizing granulomas seen only on microscopic examination. There is not a macroscopic lesion. And the same is true for vasculitis. That's also a microscopic finding.

Q. When one suspects a patient having

an inflammatory condition causing a vasculitis or an arteritis, what kind of symptoms will you see on an upper or lower respiratory tract phenomena?

A. It depends entirely on which portion of the respiratory tract is involved and the extent to which there is involvement.

Q. What do you look for as signs and symptoms to clue you in that it might be a vasculitis or arteritis if it's involving the lower respiratory tract?

A. There really is nothing very specific with respect to a vasculitis as opposed to enumerable other conditions.

Q. How do you ultimately make the diagnosis that leads you toward the conclusion that the patient has Wegener's granulomatosis as it relates to the respiratory tract?

A. Well, if it's limited to the respiratory tract without other evidence of organ system involvement it would require a tissue diagnosis.

Q. And this is what happened with your patient?

A. Yes.

Q. Okay. And she was started on Cytoxans and immunosuppressant therapy or steroids?
A. Yes.
Q. At the time of her diagnosis, Dr. Perlman, she had some renal involvement but was not in renal failure?
A. Yes.
Q. And when she was treated with the Cytoxans and the Prednisone, did she stabilize with regard to her renal function?
A. Her renal function stabilized after a time.
Q. Okay. Do you agree or disagree that blood is a classical finding in Wegener's granulomatosis when there is renal involvement?
MR. FRASURE: Blood in the urine?
MR. MISHKIND: Well, ultimately it comes out, but.
MR. FRASURE: Okay. Fair enough.
A. Not an isolated finding.
Q. I'm not saying isolated, but hematuria is a classical financing of Wegener's granulomatosis when there is renal involvement?
A. With other findings in the urine,

yes.

Q. Okay. Do you agree or disagree that you can't rule out the possibility that blood in Vickie Miglore's urine in August of 1997 -- let me rephrase.

Can you -- would you agree with me that based upon the information that you have reviewed and the evidence available to you in looking at this case that you as an expert cannot rule out the possibility that the blood in her urine in August of 1997 was in fact the first objective sign of Wegener's even though her kidney function was normal at the time?

MR. FRASURE: Objection.

Go ahead.

A. The answer to that is I would be guessing. I think it is unlikely that the blood in her urine was related to that. If by your question you mean rule out, are you talking about absolute certainty or with reasonable medical probability or with some other degree of probability?

Q. Well, we know that there were no tests done to further determine the source of the urine so we can't to an epidemiological

certainty rule it in or rule it out?

A. That's not the basis on which I come to my answer.

Q. Okay. Tell me. I take it your opinion -- let me help you out a little bit. Sometimes I do that. Very rarely. But your opinion would be that to a probability the hematuria identified in August of 1997 was not renal in nature?

A. It was not due to Wegner's granulomatosis.

Q. Okay. Can you say that it was not renal in origin?

A. I can say that it was. When you say renal, what do you mean by renal? We'll have to get to that.

Q. That it was not representative of some dysfunction causing blood to come from the kidney as opposed to the lower urinary collecting system?

A. It may well have come from the kidney. She had evidence of kidney problems that could lead to bleeding.

Q. Okay. What evidence did she have of kidney problems?

A. She had a cyst in her kidney which enlarged over a period of time.

Q. And what do you base that on?

A. Ultrasound findings from some years before she developed Wegner's granulomatosis. Or CT findings. There were imaging studies that showed the presence of this cyst. And also subsequent to the diagnosis of Wegener's granulomatosis the presence of an enlarged cyst in the same location.

Q. Is it your opinion that the cause or the source of the bleeding if it was from the kidney was from a cyst as opposed to some other etiology?

A. A cyst as opposed to Wegener's granulomatosis. It forced it to say that it was coming from the kidney.

Q. Is it your opinion that it likely was not coming from the kidney?

A. I don't think that it's possible to say with absolute certainty, but it's most likely that it didn't originate in the kidney.

Q. Tell me why you can say that it most likely did not originate in the kidney?

A. Because on a statistical basis most

patients who have hematuria don't have a renal origin and because there was an absence of protein in the urine.

Q. Okay. Do you know what time this dipstick, urine dipstick was done?

A. No.

Q. Do you know whether it was fasting or nonfasting?

A. No.

Q. Would you agree that depending upon when it was done and whether or not she had eaten or not eaten that that can influence whether or not on a urine dipstick you do or do not have evidence of protein?

A. In someone who has etiopathic protein uria that may have an influence, but not have any underlying renal disease.

Q. Is it your opinion that if there is -- if the hematuria is renal in origin that on a urine dipstick you are always going to see protein uria?

A. I have to come back and ask you what do you mean renal in origin?

Q. From the tubule, from the glomeruli, from the basement membrane emanating

from the kidney.

A. If you are talking about glomeruli bleeding I think that you will see protein as an ordinary finding. It would be atypical to a high degree to see bleeding in the absence of the presence of protein.

Q. What about in a patient that has developed crescentic glomerulonephritis? When you talk about a necrotizing glomerulonephritis or crescentic organisms --

A. It's the same.

Q. So your opinion would be that you would expect to see as an early sign of a nephritis involving the glomeruli, you would expect to see along with that hematuria protein?

A. I would expect to see protein as early as or before the development of hematuria.

Q. And based upon your knowledge and training and experience in reading the literature, how frequently does hematuria appear in patients that are subsequently diagnosed with necrotizing crescentic glomerulonephritis with hematuria as a

presenting feature without protein?

A. I was unable to find evidence of that. That's why I did the Med Line search.

Q. So your research came up with zilch, but you are not able to say to an absolute certainty that you research was --

A. I am saying with reasonable probability that's the way -- if one looks in the textbooks, Scientific America Medicine, you will find the finding in the urine described as being protein and blood. That the two are in the same sentence. I think that is pretty much how it's described in every source that I ever remember having read without having gone back to look them up.

Q. So you would then be surprised to see some literature, reliable literature that speaks to the contrary of the proposition that you are advancing right now?

A. Well, if the literature said that it was more common to see blood alone without protein in Wegener's then I would be surprised.

Q. Okay. Now, I'm saying would you be surprised to learn that there is literature out there that says in a sizeable percentage of

cases, perhaps as many as 30 percent of cases, that hematuria, when you are dealing with a crescentic or a necrotizing granulomatosis presentation secondary to Wegener's, that protein -- the absence of protein is -- the absence of protein is present in 30 per percent of the cases?

MR. FRASURE: Hematuria would be present but the protein absent?

MR. MISHKIND: Yes.

A. I have not seen that literature. I would like to.

Q. Okay. So you would be surprised to see that?

A. Well, I would say that I don't like to be surprised by anything anymore. But it's not something that I am familiar with.

Q. You would certainly not rely on a urine dipstick to make the diagnosis as to whether or not the patient has a nephritis, would you?

A. Well, nephritis is a histologic diagnosis.

Q. Okay. And how would you go about making that?

A. That requires tissue.
Q. Okay. What about glomerulonephritis?
A. The same is true.
Q. Well, if you have blood in the urine, what signs and symptoms do you need to see to cause you to think this is urinary tract infection versus renal disease or renal dysfunction?
MR. FRASURE: Just blood in the urine.
Q. Without evidence of protein, without evidence of leukocytes, without ketones and without glucose?
A. Are you saying that this would be more likely renal than some other source and glomerulonephritis specifically as opposed to a renal cyst?
Q. I guess what I'm saying is as a clinician, as a reasonable and prudent clinician, what signs and symptoms would you expect to see or would you need to see in a patient that also had a three plus blood on their urine dipstick to be thinking is this urinary tract in origin or is this renal

dysfunction?

MR. FRASURE: This is with or without kidney test?

A. Your question is not clear. I mean you are going to -- I can work through it piece by piece, but it doesn't make sense to me as a physician.

Q. All right.

A. You may have a hard time expressing it, but we'll work towards that.

Q. Well, let me -- I'll come back to it in a different way because I don't want to make it too difficult for you.

A. All right. I'm going to try to make this as easy as possible for you.

Q. And this is one of my efforts. Do you -- what percentage of patients with Wegner's granulomatosis have positive evidence of protein on a urine dipstick when they have three plus blood as well?

A. Well, three plus blood is a qualitative determinate. I would expect that the majority of them, if they have active nephritis, would have protein present.

Q. The majority being more than 50

percent?

A. I would think that it would be substantially in excess of 50 percent.

Q. Can you be anymore precise?

A. I can't. I simply have to go on what the books say which are the two are seen together.

Q. What books?

A. Take Scientific America Medicine. They are mentioned in the same sentence.

Q. Wegener's granulomatosis is an uncommon disease, true?

A. Yes.

Q. It's rare to experience it in the family practice or a general practitioner's office?

A. It's uncommon.

Q. It's certainly something that you are aware of even though it's uncommon to experience it, true?

A. With -- yeah. With an appropriate set of symptoms and findings it's something that should enter into the realm of possibilities as a diagnosis.

Q. So even though it's uncommon, it's

not okay if a doctor fails to order a test that likely would lead to the diagnosis of a rare or uncommon disease if the signs and symptoms of that disease are present to be appreciated, true?

A. If a constellation of the signs and symptoms are present, yes.

Q. Okay. Would you agree that if blood in the urine is not secondary to an infection and the women is not having her period it's not a benign finding?

A. No.

Q. You would not agree with that statement?

A. Well, let me ask you what you mean by benign.

Q. What do you mean by the word benign?

A. Benign means something that is not portending a life-threatening or debilitating disease.

Q. Okay. So do you find blood in the urine that's not secondary to infection and not secondary to a woman having her period to be a benign or a nonbenign finding?

A. It is often benign. It is sometimes not benign.

Q. Under what circumstances would it not be benign?

A. If it were representative of serious structural diseases of the kidneys such as a cancer. A tumor somewhere. As a manifestation of stone disease that was causing an obstruction. As a manifestation of a whole host of other kidney diseases.

Q. Such as?

A. Basically polycystic or other cystic kidney diseases. Polycystic particularly because it leads to renal failure. The presence of blood would also be serious in the case of an active destructive process of kidney due to any number of conditions.

Q. Such as?

A. Well, such as basically infection, inflammation or tumor.

Q. What about vasculitis?

A. Well, vasculitis is a form of inflammation.

Q. How do you go about working up a patient where you consider the blood not to be

secondary to infection and not to be related to period if you deem it not to be a benign finding?

MR. FRASURE: Blood only now?

MR. MISHKIND: Yes.

A. I refer patients to a urologist.

Q. Okay.

A. And I have them perform studies to look for structural disease of the upper and lower urinary tract.

Q. Direct upper and lower urinary tract, would that include the kidneys?

A. Yes. Now, that doesn't include tissue.

Q. Is your line of referral always to a urologist if there is blood and it's considered not to be benign?

A. Yes.

Q. You don't refer to a nephrologist?

A. No.

Q. Do you have any explanation in this case based upon your review as to why Dr. Cola thought that Vickie Miglore had an infection on August 27th given the negative lab work of August 21st -- the negative leukocytes in her

urine from August 13th?

A. Let me find a transcript of his note, if I can do that.

Q. I think you have it right in front of you there.

MR. FRASURE: Yeah.

A. Well, she reported that she had problems with boils on her buttocks and face which are generally of infectious origin. She had weakness which is a nonspecific finding, but is compatible with infection. And I guess those are the two findings that of the symptoms she's got that would most specifically suggest the presence of that.

Q. But again, in light of the fact that she just had blood work that showed that she did not have an infection, and in light of the fact that her symptoms of weakness had existed on the 13th when she was referred to the hospital for blood work?

A. What blood work are you referring to that said that she didn't have an infection?

Q. Did you look at the labs from Barberton Citizens Hospital?

A. Yes, I did. That's why I'm asking

you, what blood work are you talking about that says she didn't have an infection?

Q. Do you have any evidence that would suggest that she had infection?

A. I don't see any evidence that she did or didn't. And there are abnormalities there such as abnormal liver enzymes that are sometimes seen in infection.

Q. She had a long history of fatty liver disease, had she not?

A. Yes, but that doesn't necessarily mean that that was due to infection or not due to infection.

Q. Well, based upon your review in this case, was Dr. Cola's thought process that that fatty liver was a benign or a nonbenign finding?

A. Well, he had her get an ultrasound which was done on the 26th to look for this and if he thought it was benign, I don't think he would have pursued the issue.

Q. Your read of this case is that he had her get an ultrasound which was done on the 26?

A. There is a report on the ultrasound

saying there is a prominence of bile duct.
Q. Where was the ultrasound done based upon your review?
A. I have to go back and find it.
Q. Do you know as you sit here right now?
A. I have to go find it. I don't like to guess.
Q. I'm not suggesting that you guess.
A. That's why I'm saying if I look it up, I can tell you.
Q. Well, obviously, I want to know what information you have as an expert in the case, so sure.
A. On August the 21 she had an ultrasound of the abdomen. Of the upper abdomen. And that was the date that it was performed.
Q. Okay. And do you know where that was performed at?
A. At Barberton Citizens Hospital.
Q. Okay. Now, did she have any leukocytes in her urine on the urine dipstick?
A. No.
Q. That would suggest against

infection, would it not?

MR. FRASURE: All infection or urinary tract?

A. What kind of infection are you talking about?

Q. When you don't see any leukocytes what does that tell you?

A. It suggests that there may not be a lower urinary tract infection.

Q. Okay.

A. Lower being the bladder or the urethra.

Q. But you can't necessarily rule out infection where you have a dipstick that shows no leukocytes?

A. That's correct.

Q. And just as you can't necessarily rule out protein in a urine dipstick if the urine dipstick shows an absence of protein?

A. Oh, I think that you can rule out the absence of protein in urine in a negative dipstick. Rule out the presence of blood cells with a negative dipstick. By the same token if you receive positive findings, you can say that there is evidence of protein or blood. I think

that the two have good sensitivity.

Q. You can't identify red blood cell casts in a urine dipstick, can you?

A. No.

Q. Okay. You need to do microscopic urinalysis, correct?

A. Yes.

Q. So that you can't identify whether there is any morphologic changes in the red blood cells or dysmorphic changes in the red blood cells by looking at the dipstick, true?

A. You can never say that there are not casts present.

Q. Based on what?

A. The cast is composed of blood cells and protein. And if you don't see protein in the urine, you can infer it's less unlikely that there are going to be casts present.

Q. Based upon a urine dipstick?

A. Have you heard what I said?

Q. I sure did, and that's why I'm asking you the question.

A. I said you can infer that.

Q. Well, let's not -- I don't want to play games with language. When you say you can

infer it, is it your opinion that it's a reasonable and prudent practice on a doctor's part when they see three plus blood on a urine dipstick and no protein that they can conclude that there is no -- that there are no red blood cell casts?

A. You can't conclude with it certainty, but you can infer in all likelihood that there are not going to be casts present.

Q. So your testimony would be that it would be reasonable and prudent to make that conclusion thus obviating the need to do a microscopic urinalysis?

A. No. What I'm doing is taking a pretty specific look at the case. I'm saying what is the likelihood that she had red blood cell casts present at the time of that urine sample that was obtained in August of 1997. And by the absence of protein in the urine, I am inferring that it is unlikely that there are casts present.

Q. Whether it was appropriate or inappropriate not to order it at that time, you are just making the statement that it's unlikely that it would have been there had it

been ordered?

A. Correct.

Q. Okay. We'll talk about the appropriateness of not doing it in a moment.

A. Right. I didn't get on to appropriateness.

Q. Okay. Can we agree that a repeat urinalysis should have been ordered on Vickie Miglore?

A. At some point within the next four to six weeks, yes.

Q. Do you see any evidence in the records of Dr. Cola that he had any plan to repeat the urinalysis in four to six weeks?

A. No, not in the records.

Q. Do you know why Dr. Cola did not obtain a repeat sedimentation rate when he ordered blood work on August 13th?

A. I don't know why he didn't. That's not a test that is typically done on a patient.

Q. So you would not be critical of him for his failure to order an repeat sedimentation?

A. I don't think it represents a failure. I'm not critical for him not doing

it.

Q. Would you agree it's a breach of standard of care for a general medical doctor not to do a complete urinalysis as soon as possible once he knows that there is an abnormal urine dipstick?

A. I don't agree with that statement in several aspects.

Q. Tell me why.

A. Please rephrase so I can answer each one. Each issue.

Q. Well, you said that you don't agree with it.

A. The sentence contains several components. Go through each one.

Q. I asked you whether it's a breach of standard of care for a general medical doctor not to do a complete urinalysis.

A. Number one, as soon as possible?

Q. Right.

A. Then I would ask what do you mean as soon as possible?

Q. Why did you pick the four to six week period? What caused you to say that?

A. Because hematuria is often a

transient finding in the urine often due to benign causes. If it's in fact transient, the easiest way to document transience is to go ahead and repeat a urinalysis at some point some weeks later. And if the blood is not present at that point then it makes it unlikely related to any kind of a serious disease. That spares the patient complex and expensive and often unnecessary evaluation.

Q. Okay.

A. It puts them at little risk for missing any substantial disease waiting a time period of four to six weeks.

Q. Well, we know that Dr. Cola did a urine dipstick on August 13 and had three plus blood in the urine?

A. Yes.

Q. We know that two weeks later he has information conveyed by the patient that she is experiencing weakness, sweating, not urinating as much, has pain, little appetite, severe neck and jaw pain and is now broken out in boils with boils on her buttocks and her face. Given those additional symptoms would you agree that that patient should have been scheduled for an

office visit with Dr. Cola?

A. No.

Q. Why?

A. Because he formulated a working diagnosis to account for the symptoms, suspected it might be related to infection, and prescribed a broad spectrum antibiotic which is effective in treating these types of infections. And it would be reasonable to have her treated for a period of time to see if she responded.

Q. To your knowledge, did he talk to the patient?

A. No.

Q. Do you diagnose patients over the phone without talking with the patient?

A. Yes, as a working diagnosis.

Q. Isn't it reasonable and prudent to have the patient come in where there are symptoms of what would be considered to be of a relatively significant nature as described by the patient?

A. Those that you enumerated wouldn't lead me to bring a patient to the office.

Q. Okay. What was within Dr. Cola's

differential based upon the patient's complaints as conveyed by her through the receptionist and then to him?

A. Well, as I say, I don't think he performed what you call a differential which we defined earlier as an exercise. I think that he formulated a working diagnosis and a treatment based on that working diagnosis.

Q. All right. What was the working diagnosis?

A. An infection.

Q. That was the extent of what you understood him to be thinking of?

MR. FRASURE: We're talking about on the 27?

MR. MISHKIND: Yes.

A. I'm looking at boils and boils are an infection.

Q. Boils --

A. That's what they are to me.

Q. Boils are also consistent with vasculitis, are they not?

A. They are not a common feature, no.

Q. Doctor, if you looked at the signs and symptoms of Wegener's granulomatosis or

glomerulonephritis, would you agree that skin lesions or boils are characteristic of it?

A. Certain types of skin lesions are. A boil which is medically known as an infection is not a typical lesion of a vasculitis.

Q. Would that be associated -- tell me what his thought process was in terms of referring a patient to a neurologist?

A. I can't tell what his thought process was.

Q. Would you have referred the patient to a neurologist?

A. I think with a variety of nonspecific complaints of the sort that she had that would be one route of investigation.

Q. And if one is going to refer a patient to a neurologist, obviously, you would have to have a working diagnosis in your mind for selecting the neurologist, what was he thinking about that caused him to want to send her to a neurologist?

A. I can't tell you what he's thinking about. I think they present symptoms of malaise and fatigue which may be due to a variety of neurologic conditions.

Q. Well, you have reviewed the case. It's important that you have information as to his thought process before you provide opinions as an expert, don't you agree?

A. I don't think I need to see his thought process. I need to see what his actions were.

Q. Okay. Well, but tell me what his actions were based upon when he said to someone that he wanted to refer her to a neurologist?

A. I can put myself in his shoes and tell you what my thought process would be, but I can't tell you what his would be. I can come up with what to me is a medically reasonable rational for doing that. If you would like me to explain that I can explain what my thought processes are.

Q. We'll get to that in moment as soon as we deal with my question. And my question is, from your review and based upon your careful evaluation of the facts, what did Dr. Cola say was the predicate for which he thought a referral to a neurologist would be in order?

A. Generalized pain on the visit of August the 13th. Also of chest pain or

cervical pain with muscle tension headache.

Q. Okay. And again I ask you these questions because as an expert witness it's a search for the truth. Certainly you want to rely upon information, accurate information when you provide opinions in this case, correct?

A. Yes.

Q. Okay. Now, let's talk about what you would have been thinking about that would have potentially caused you, Dr. Perlman, to think neurological consult?

A. All right. We would like to go back to the visit of August the 13th.

Q. Well, I guess what you are, what you are taking is the 13th as well as now the additional symptoms that are presented on the 27th, true?

A. And the studies that were performed and the trial of treatment that was carried out as a result of the visit on the 13th and also -- well, chiefly on the 13th.

Q. Okay. Tell me.

A. Go through that with you?

Q. Yes.

A. Let's go to the note of August the 13th. First complaint. Has had headache of neurologic origin. Generalized weakness. Nonspecific. May be neurological. Felt arm tingle and of neurological origin.

He performs a physical exam which doesn't reveal any clear cut explanation and has not really performed a neurologic exam. Comes up with a working diagnosis of cervical pain with muscle tension headache and some generalized pain. Prescribes a series of physical maneuvers to see if he can alleviate the pain consisting of manipulations and hot packs. Also a trial of a muscle relaxants. And performs a number of studies to look for a metabolic explanation for the problems. These tests come back. She reports to him on the 27th with complaints you have enumerated. And in my mind that would again imply the possibility of infection given the presence of boils and a persistence of the complaints that were enumerated at the visit of the 13th. And having done the evaluation and the trial of treatment that was performed back on the 13th, and having the benefit of the ultrasound test,

I think it would be quite reasonable to pursue an evaluation with a neurologist to look for an explanation for some of these symptoms.

Q. Doctor, I have listened to you giving this triad of what I already know in the records. But what I was hoping to hear you tell me was what neurological conditions would you be thinking of?

A. What I would be thinking of as a physician?

Q. Yes.

A. I would be thinking of the possibility of cervical spondylosis. I would be thinking of the possibility of a VNS function, that's vascular nervous system, related to tumor. To encephalitis or encephalopathy. I would consider the possibility of depression very strongly. Demyelinating disease such as multiple sclerosis as being a couple of the things that would come to mind immediately.

Q. Vickie Miglore was never given a referral to a neurologist in this case, true?

A. True.

Q. Vickie was never even communicated

the message that Dr. Cola had noted in the record that he wanted her referred to a neurologist, true?

A. I don't see any written evidence that that was the case.

Q. You don't have any evidence to suggest that she was told by Dr. Cola or by somebody from the office see a neurologist and she then said I'm not interested and ignored it?

A. I don't recall from the deposition testimony.

Q. No antibiotics were ever ordered or prescribed for Vickie Miglore, were they?

A. Was the Augmentin not prescribed for her?

Q. You tell me, doctor.

A. Well, I see that it was prescribed. I don't know if it was actually telephoned to a pharmacy or not.

Q. Okay. Can we agree that the thought process of the doctor in terms of recommending Augmentin was never communicated to the patient in this case?

A. That I don't know.

Q. And again, it's important to understand what information was or was not conveyed to the patient when you provide opinions?

A. Right. I can't tell you one way or the other whether that was conveyed.

Q. Has anyone told you or have you seen anything from the deposition or the information that you reviewed that would permit you to say that someone did tell Vickie Miglore that Augmentin was the doctor's preference and that they wanted to order it for her?

A. I don't have a basis for saying that one way or the other.

Q. Okay. Dr. Cola never talked to Vickie about the liver test being elevated, did he?

A. Not directly, no.

Q. Vickie Miglore was never given an appointment --

A. Let me clarify. In that set of tests that was obtained in August?

Q. Correct. Right. Vickie was never given an appointment in six weeks for a recheck on her liver enzymes, was she?

A. I don't believe the office scheduled one.
Q. A microscopic urinalysis was never scheduled, correct?
A. Correct.
Q. The records don't reflect a microscopic urinalysis was within the plan of treatment at any time while Dr. Cola was her physician, true?
A. That's right.
Q. And from all that you have reviewed can we agree that Vickie Miglore was never told by Dr. Cola or his office that she had blood in her urine?
A. Correct.
Q. Can we agree that any patient, whether it's Vickie Miglore, Perlman or Howard Mishkind that if you have blood in the urine you are entitled to know about that?
A. I think that you are entitled to know about it, yes.
Q. And you are entitled to know about it and should know about it especially if there are additional tests that need to be done to determine whether or not the blood in the urine

is benign or otherwise, true?

A. Yes.

Q. Can we agree that fever, general malaise, decreased urinary output, hematuria and pain on the side or the small of the back can all be signs of kidney as well as urinary tract disorder?

A. Read the symptoms to me again.

Q. Sure. I believe I said fever, general malaise, decreased urinary output, hematuria, pain on the side or small of the back can all be signs and symptoms of kidney and urinary tract disorder?

A. Yes.

Q. Okay. If a patient comes to you complaining of pain in her side radiating through to her back that was continuous, she had general malaise and hematuria, would part of your differential include kidney disease?

A. Not kidney disease per se, but symptoms emanating from the kidney.

Q. Such as? I don't mean to be redundant.

A. Kidney stone or urinary tract infection.

Q. What about nephritis?
A. No, I don't think that's a typical symptom.
Q. Would you rule out nephritis based upon that?
A. I wouldn't begin to think of nephritis.
Q. You wouldn't rule it out though based upon those symptoms?
A. I don't consider those symptoms to be representative of nephritis.
Q. Okay. If the patient came to your office with these symptoms is it your suggestion that part of your differential would not include kidney disease?
A. First of all, I don't necessarily formulate the differential. I think we discussed that earlier.
Q. Right.
A. And secondly, intrinsic renal disease would not be a significant component of those symptoms.
Q. On Dr. Cola's record for the plan he had a UA marked down on his record on August 13th?

A. Can I go back to that other question? I would consider cancer in the kidney as a potential symptom.
Q. Okay.
A. Okay.
Q. Anything else you wanted to add?
A. No. That's okay.
Q. Dr. Cola had a UA marked down or urinalysis on August 13th as part of his plan?
A. Yes.
Q. He did a urine dipstick?
A. Yes.
Q. That's a different creature, is it not?
A. Well, it's a different creature. The question is by his writing it in this way is that what he had intended to have done? I suspect it was.
Q. Why?
A. That's how the tests are performed in many practitioners' offices.
Q. When he sent Vickie to Barberton Citizens Hospital do you know whether he had the information about the three plus blood from the dipstick?

A. At what time are we talking about?
Q. Prior to her leaving the office.
A. I don't think he had that information.
Q. And what do you base that on?
A. Because I believe what he did was he wrote the order for the nurse to do the studies and she did the studies and gave her orders to take off to Barberton Citizens for the studies aside from the urinalysis which was probably after he saw the patient.
Q. Well, would it surprise you to know that number one, the urinalysis was done early in the visit and after she was seen by Dr. Cola she had high velocity treatments and was at the doctor's office for a period of time such that the urinalysis, the blood, the urine dipstick results were in the chart and were available for Dr. Cola long before she had left?
A. Are you saying that she gave the urine sample or are you saying that she actually had the test? The tech had actually done the test and put the results on the chart?
Q. Let's assume that she gave the sample and that the results were posted in the

chart and available to the doctor before Vickie left. If that were the case and she's then sent over to Barberton Citizens Hospital after having treatment with the treatments for the therapy. --

A. Yes.

Q. -- with a prescription that shows CBC, et cetera, would it be reasonable and prudent to have a UA and a culture sensitivity done at that time?

A. No. I don't believe that's necessary.

Q. What would be necessary as it relates to follow-up on that three plus blood?

A. If he was aware of it he should have basically, when the final reports are communicated to the patient, said you need additional tests within six weeks.

Q. And if the patient calls for the results of the tests that she's had, the blood tests that she's had, okay?

A. Yes.

Q. Is the patient entitled to be informed of the results of the blood test?

A. I think in a general sense that

they are normal or not normal.

Q. If a patient calls and wants to talk to you and has had a change or a worsening in their condition and wants to talk to you, do you return telephone calls to your patients?

A. I typically do when time permits.

Q. Do you see any evidence that Dr. Cola made any attempt to communicate with Vickie Miglore after August 13th?

A. Not directly, no. I can go back and look at the record if you want me to.

Q. No. That's okay. Your answer stands. I understand what you are saying.

What are you looking for?

A. His office notes. The handwritten notes.

Q. Doctor, let me make it easier for you. There is some suggestion that Dr. Cola may have fielded a telephone call that Vickie made on August 20th. That it is in dispute as to whether or not he actually spoke to her on the 20th or whether information was conveyed to him. In any event, what I was getting at was with regard to telephone calls that Vickie made where she wanted to talk with the doctor. Is

there any indication that Dr. Cola called her back to communicate information to her?

A. Well, there is a note in his writing on the 22nd and I'm not sure what it says. But it's in his handwriting.

Q. And the 22nd is actually, to help you out, doctor, it's actually a reflection on the August 20th note and that's the one that I just referenced, that there is some dispute as to whether he actually spoke to her or whether information was conveyed through a telephone call that she made to the office. I'm talking about other than --

A. Well, I can't. No. Other than that, I don't see that he spoke with her. I can't conclude whether he did or didn't on the 20th based on what I can read here.

Q. What does a BUN and creatinine tell you about kidney function?

A. It tends to indicate whether or not the kidneys are adequately performing a function in terms of filtering toxins out of the body. It also gives some indication as to the relative efficiency of that process.

Q. Can the kidneys compensate when

only a small portion of glomeruli are damaged?
A. What do you mean by compensate?
Q. Can the kidneys perform their function when only a small portion of the glomeruli are damaged?
A. Yes.
Q. In early kidney disease are BUN and creatinine always elevated?
A. What do you mean by early kidney disease?
Q. When there is a small portion of glomeruli damaged.
A. When there is disease of clinical significance they'll become abnormal.
Q. In early kidney disease BUN and creatinine is not elevated until there is some evidence of permanent kidney damage, true?
A. No.
Q. When do you start seeing elevation of the BUN and creatinine?
A. The minute the functional capacity of kidneys is impaired for any variety of reasons. When you talk about functional, I'm presuming you are talking about whether the kidney is able to function to a point of

avoiding uremia, avoiding problems of fluid retention and the like? Those can all occur without any substantial elevation in the kidney function test. But I would say that if there is a reduction of kidney function to a meaningful degree from a functional standpoint it's going to show up in the BUN and creatinine being abnormal.

Q. On August 26 when Dr. Cola had the results back from Barberton Citizens Hospital did he have any evidence at that time that would cause him to suggest that she had an infection?

A. In what area?

Q. In any area of her body.

MR. FRASURE: This is as of 26th because we went over the 27th.

MR. MISHKIND: Right.

Q. I'm talking about as of the 26th.

A. Okay. What's come back, the blood tests?

Q. Yes. The blood tests. He's got the ultrasound, and he has the, the, the heretofore mentioned urine dipstick.

A. The abnormalities of the liver

enzymes, the GGTP, the AST and the ALT may indicate the presence of infection.

Q. Are they within normal laboratory limits according to Barberton Citizens Hospital? Are they considered to be abnormal?

A. Those specific tests are considered to be abnormal.

Q. You would look at those as indicia of a possible infection?

A. They may be. I left out the LDH.

Q. Well, would LDH be a sign of infection?

A. It can be.

Q. Could you use LTD and elevation of LDH as a sign of infection, doctor?

A. Not ordinarily.

Q. What is LDH normally indicative of?

A. It's indicative of tissue damage. Infection can be a cause of tissue damage.

Q. Would you expect to see other markers of infection before you would start looking to LDH, elevation in LDH?

A. Often you would.

Q. Okay.

A. Yes.

Q. And what would you look to?
A. I would look to a presence of absence of fever from a symptoms standpoint. Presence or absence of localized symptoms related by the patient. And I would look to abnormalities of physical findings if I actually performed an exam at the time that the tests were obtained. I would look at the blood count for evidence of either a high or a lower white blood count or evidence of a change in the differential count of the neutrophils, lymphocytes or monocytes.
Q. Was there any evidence of infection based upon the white blood count?
A. Not as of the 21st of August.
Q. Again going back to the 26th. Other than what you have identified as potential signs of infection, can we agree that normally you would be looking to elevations in the white blood count as being the laboratory tests that would give you the most valuable information as to whether or not the patient has an infection?
A. Well, let's decide on what date we're talking about trying to make that

determination that the patient has an infection or not.

Q. Well, he doesn't, when does he gets the results back from the lab?

A. Well, the results come back on the 26th I believe but they were obtained on the 21th.

Q. I'm asking you as of the 26th looking at results. I'm looking at what was tested at Barberton Citizens Hospital, correct?

A. Yes.

Q. Okay. So he's looking at the lab values and if he's looking to see if there is evidence of infection he's going to look at the white blood count, true?

A. Among other things, yes.

Q. Okay. Well, the white blood count would be the first area that a clinician would look to for evidence of infection, right?

A. It would be a significant one.

Q. Okay. And there is no evidence of infection based upon the white blood count, is there?

A. On the 21st of August.

Q. On the 26th what he's looking at is

information. Does he have anything before he talks to her on the 27th? Does he have anything that would cause him to be thinking infection in this patient?

A. The abnormalities of AST and ALT are possible indicators of infection.

Q. Okay. The ultrasound of the abdomen was essentially normal, was it not?

A. No.

Q. The ultrasound of the abdomen was essentially normal?

A. No, it showed changes.

Q. Would you agree with me that essentially those findings in Vickie Miglore were of no clinical significance?

A. Not with respect to her ultimately developing Wegner's granulomatosis.

Q. That's not my question. At that time as the clinician on August 26 would it have been reasonable to conclude that the ultrasound results were of no clinical significance?

A. No.

Q. Okay. So you think that Dr. Cola should have been concerned about the ultrasound

results on August 26th?

A. In conjunction with the liver enzymes that are a repeat of enzymes would be an appropriate test to do.

Q. But looking at the ultrasound a reasonable and prudent doctor such as Dr. Cola should not have indicated that the ultrasound results were essentially normal and of no clinical significance, true?

A. I would say that they are of no immediate concern.

Q. Were they normal and of no clinical significance?

A. They were not normal. And they were not of no clinical significance.

Q. And any reasonable doctor as of August 26, 1997 should have concluded that, true?

A. Yes.

Q. Okay. Is pain radiating through to the back, is that considered flank pain?

A. I don't know what that is considered. That's not a sufficient description to really be precise at all in terms of origin of pain.

Q. It's incumbent upon the doctor to get a better explanation from the patient to determine whether or not that's true flank pain, true?

A. I wouldn't agree that it's incumbent. I think that's helpful if you are trying to evaluate the pain further.

Q. Well, if you have the patient in the office and the patient is complaining about pain in the side radiating through to the back, one of the things you want to determine as a clinician is is this flank pain?

A. Well, I would ask them to explain why does it hurt. In other words, when it was recorded by the doctor it may have been entirely clear to him where the location was and it wouldn't be necessary for him to state it's located in a certain precise area if it was apparent to him and the notes were for his own reference in putting together her total symptoms.

Q. Is flank pain, generalized weakness and blood in the urine, three plus blood, of any significance when you put those symptoms together?

A. They don't add up to a specific condition.

Q. Can you rule out -- what conditions would you consider in your mind when you are faced with weakness, flank pain radiating in the back and blood in the urine?

A. I don't but those three together as being anything. I think that I would put together the flank pain and blood in the urine as possibly indicative of a kidney stone.

Q. Okay. And what type of test would you do to rule out kidney stone?

A. Typically an IVP, intravenous pyelogram.

Q. Was an IVP ever recommended to Vickie Miglore in this case?

A. No.

Q. Was Vickie Miglore ever referred to a urologist?

A. No.

Q. If you are concerned that the patient has some sort of vasculitis that precipitates the weakness, the decreased urination, the boils, the hematuria of two weeks earlier, the difficulty breathing,

shortness of breath that have been evident, the swelling of the hands and the feet, what lab tests, if any, would you consider to rule out or confirm the presence of a vasculitis?

A. I wouldn't even get to the point of thinking vasculitis was a reasonable consideration based on the symptoms she presented with in August.

Q. Tell me why?

A. Because first of all, let's go back to the two complaints she had. Let's get to the transcript of the note here. I want to read the note that is typed. There it is. Because one is confronted with a whole bunch of different symptoms and you don't abstract certain components of the history and say, oh, we will look at the generalized weakness at the hands and knees, swelling and ignore the fact that she also complained that she was getting headaches with neck pain, that she was having trouble with insomnia, that it was difficult to eat, that she seemed to bloat, that her voice was cracking, that it was hard to sit in the car and hard to move certain ways. If you'll look at the totality of the note, that doesn't

begin to suggest vasculitis as being a likely condition.

Q. So the fact that there are symptoms consistent with it and symptoms that are not consistent with it you would think away from vasculitis?

A. If you are trying to come up with a single disorder or a couple of common disorders then you would think away from vasculitis. That is I would say almost never on the top of a list of diagnostic probabilities of a patient walking in the office.

Q. Doctor, do you always look for a simple or common disorder to explain symptoms?

A. If possible, yes.

Q. Okay. But if you always think about simple and common disorders, you can agree that you are going to miss some of the less simple and less common disorders, aren't you?

A. When you say miss, are you talking about at the time of the initial visit or are you going to talk about at the time the evaluation is ultimately concluded?

Q. Well, when did he ultimately

conclude his evaluation?

A. He never did because she left his practice.

Q. To Dr. Cola when did he become aware of the fact that she left his practice?

A. He was aware she left his practice when she requested her records and they were transferred.

Q. That's at the end of December?

A. Right. Or in December. I'm not sure of the exact time.

Q. What efforts did he make to follow through and to get additional tests and to prescribe antibiotics and to get the referrals to this patient after August 27th?

A. I think it was communicated to the patient according to her understanding that there were abnormalities on her tests and that he wanted to see her again. And I think that that was the effort that was made. And she chose not to return.

Q. Now, so you are accepting what she said in her deposition, true?

A. Well, I'm accepting that particular component of what she said.

Q. Okay. Yet we can agree that there is nothing in Dr. Cola's records that would suggest that any abnormalities were communicated to her, that anybody said anything about coming back for any tests let alone any period of time if we rely on the records, true?

A. No. I think if we look at the records there are notes here that say on the 26th that he wanted to recheck the enzymes and also on the 27th that he wanted to prescribe augmentin and that he was referring her to a neurologist. So I think that there were recommendations that he was making.

Now, I can't say that this confirms that the recommendations were explicitly conveyed to the patient. There was clearly communication with the office and Mrs. Miglore. The exact substance of those conversations I guess is open to some contention. I won't comment on them one way or the other, but there was communication there.

Q. Let me ask you this, doctor, because you made a point of referencing that she said that the doctor did want to repeat some tests and you are referring -- you are

grabbing her deposition transcript now, true?
A. Well, I'm not grabbing it.
Q. You are seizing the moment. However, you also know that she testified that she called on three or four occasions after August 27th wanting to talk to the doctor, wanting to get the results of her tests and that Dr. Cola did not get on the phone and Dr. Cola never called her back, is that true?
A. I'm aware that she said something to that effect.
Q. And she testified that she had difficulty with getting referrals to other doctors done in a timely basis.
A. I don't recall that specifically, but I won't deny that.
Q. You are also aware that she was in contact with Dr. Cola's office on at least two or three occasions where there are notes made in the chart with her calling for referrals to two specialists, Dr. Torok and Dr. Schirack, true?
A. Yes.
Q. Yet no efforts were made on those dates to communicate with her that we've got

some unfinished business. We've got hematuria in your urine. We have an antibiotic that we want to prescribe. You need to see a neurologist. There doesn't appear to be in the record any effort to have communication after August 27th with this patient, true?

A. That would appear to be the case. Although I see something here about needs referral faxed and test results faxed on the 24th of October.

Q. Let me submit to you that if the test results that were faxed and the evidence in this case supports that the blood work was faxed to Dr. Schirack and the testimony in this case will be that when Dr. Schirack saw the blood tests he was not provided with the hematuria, the blood results, he was -- the hematuria, the urine results, he was provided -- he was provided with the labs for the blood and nothing more, certainly the hematuria in the urine is an important component of the workup on this patient, is it not?

A. Not for the gastroenterologist.

Q. Certainly for the primary care

doctor who has a duty to follow-up on the hematuria it's an important piece of information, true?

A. Yes. It's important that he follow-up on it.

Q. There is no evidence that he did follow-up on that, true?

A. There is no evidence that he ordered further tests, no.

Q. And would you have ordered further tests if she were your patient?

A. She was expected to come back to my office. That's the point at which those would have been obtained.

Q. Is there evidence in the records that there were any appointments scheduled that she missed?

A. No.

Q. And there is no evidence that appointments were offered to her, correct?

A. I think it was indicated that they did want to see her.

Q. And the testimony also, if you are going to accept her testimony, was that she wanted to schedule an appointment, she wanted

to talk to the doctor and she was not given an appointment and the doctor didn't call her back?

MR. FRASURE: Objection. I don't think that's completely right, but go ahead.

A. The impression that I have which I have to go back to relate, was that she was informed that there were abnormalities in the tests, that the doctor wanted to see her again. That she wanted to talk to the doctor before she came back to the office. That's my impression.

Q. Okay. And she wanted to talk to the doctor before she came back to the office?

A. That was my impression.

Q. Okay. Now, on September 11th she sees Dr. Torok?

A. Yes.

Q. And Dr. Torok in his note just 14 days after Vickie had called Dr. Cola's office with the complaints that we've talked about, she has Dr. Torok's analysis, a number of constitutional symptoms that sound like some sort of a possible inflammatory problem. Is the description of possible inflammatory

problem where a patient has pain and swelling in multiple joints, numbness as well as the previous symptoms that you are aware of, are those symptoms consistent with the type of joint pain that you see in Wegener's granulomatosis?

A. Joint complaints are not an prominent component or constellation of symptoms in terms of making the diagnosis. Typically in an inflammatory arthritis one would see physical manifestations of joint inflammation. I'm looking for his physical examination that shows that she has signs of joint inflammation on September the 11th. And I'm reading his note and I don't see a physical examination that's performed. Maybe I'm missing something here. But I'm reading the note of the 7th which is partially handwritten and partially dictated.

Q. You said the 7th. Did you mean the 11th?

A. The 11th. I'm sorry.

Q. By the way, are you aware of the fact that her appointment had been scheduled for the 8th and Dr. Cola's office had been

notified on the 4th that she was going to be seeing him on the 8th, yet the appointment didn't take place until the 11th?

A. I was not aware of that.

Q. Are you aware of why the appointment didn't take place until the 11th?

A. No.

Q. All right. In any event, if there are clinical signs that show an inflammatory process going on, would your opinion be different in terms of it being perhaps not a important feature but yet a feature of Wegner's granulomatosis?

A. Well, again, I'm coming back. I'm not done with this note. Are we talking specifically about the visit to Dr. Torok?

Q. If Dr. Torok in his exam or tests performed comes up with evidence of an inflammatory process would that be evidence that would be consistent with Wegener's granulomatosis?

A. It wouldn't be the most common condition. I don't see any evidence here of an examination that showed any evidence of inflammatory arthritis.

Q. Hypothetically if there is evidence of a minimal inflammatory process going on coupled with the symptoms that the patient had previously, would you agree that while it might not be a prominent feature that would cause one to jump to Wegener's granulomatosis that there is clinical evidence of an inflammatory process that would be consistent with a vasculitis that could be explained by Wegener's granulomatosis?

A. There is clinical evidence means physical findings?

Q. Yes.

A. Yes.

Q. Okay.

A. It would not be -- but again, that's the -- not a likely cause of that.

Q. I understand.

A. There are numerous arthritic conditions which are more common and more likely to produce these types of symptoms than Wegener's granulomatosis.

Q. Would you agree from your cursory review of Dr. Torok's records that he was not aware or at least it doesn't appear that he was aware of any hematuria in Vickie as being an

abnormality that was one of the abnormalities that Dr. Cola planned to follow-up on?

A. No. It looks to me like he was thinking that she had a neurological problem.

Q. Okay.

MR. FRASURE: Who is he now?

A. He being Dr. Torok. He ordered a nerve conduction study which is a test for neurologic dysfunction.

Q. It also shows inflammatory processes as well, correct?

A. Not usually. It's not one of the typical tests that is done. An inflammatory process is usually diagnosed through tissue sampling or through physical findings.

Q. What about a bone scan?

A. A bone scan can do that.

Q. And if a bone scan shows evidence of an inflammatory process would that be reason not necessarily to jump to a vasculitis, but to consider a vasculitis?

A. It depends on the findings on the bone scan. If we are talking about her bone scan, no, that wouldn't.

Q. Why?

A. Let's look at the bone scan if you would like to.

MR. FRASURE: Dr. Spoljaric's records. There is the nerve conduction.

A. Okay. Well, the nerve conduction was normal. So obviously that's not evidence for either a neurological problem or a vasculitis if you are going to contend that's vasculitis-produced abnormalities. But we'll go to Dr. Spoljaric's records and basically the bone scan showed increased uptake in the mid to lower thoracic spine and knees most likely due to degenerative arthritis. That's not inflammatory arthritis. A bone scan might show signs of inflammatory arthritis, but in her case it did not. That was done on January the 7th of 1998.

Q. Okay. The renal biopsy that was ultimately done showed necrotizing crescentic glomerulonephritis, true?

A. Yes.

Q. Necrotizing glomerulonephritis is scarring that occurs in the kidney, correct?

A. Well, scarring refers generally to what is called fibrosis which is a late stage

of healing after active inflammation. The process of necrosis is the acute injury and damage to tissue.

Q. Can you tell me from a hematological standpoint when there is the necrotizing process that occurs that ultimately leads to the scarring where along the process do you expect to see blood from the glomeruli?

A. During the active period of necrosis.

Q. Okay. And can you tell me in this case when you believe the active period of necrosis was physiologically occurring?

A. Sometime after mid January of 1998.

Q. And are you saying that based upon the patient's symptoms or are you basing it on some clinical, some study that was done?

A. I'm basing it on the symptoms, the physical findings and her clinical course.

Q. Well, that's a huge --

A. Well, I can break it down if you would like me to.

Q. I would love you to, doctor, yes.

A. I'll try to keep it simple for you.

Q. Please, that's what my mind can

handle.

A. This is complicated stuff. And I, I really would like to clarify it. But I need to get the notes from Dr. Spoljaric in terms of office records.

Okay. Well, they are in reverse chronologic order. That's why. Okay. Let's find the 12-30-97. The complaints related to Dr. Spoljaric December 30, 1997 showed that there was intermittent epigastric pain of six months duration with right sided pain increased by breathing or other movements of the torso. That implies to me continued activity of her esophageal reflux disease which was an ongoing problem and also musculoskeletal pain on the right side. The center of the pain seems in the right chest wall. Again, describing what sounds like musculoskeletal pain. She has also had numbness and tingling in the hands. And she had a nerve conduction study in October or was it September with Dr. Torok that was normal. So that we can presume that she didn't have carpal tunnel syndrome or substantial inflammation of the nerves in the wrist at that time. So I don't see anything in the history

that she has related to Dr. Spoljaric on the 30th of December that she's got symptoms of vasculitis or Wegener's granulomatosis.

In addition on his physical examination he finds tenderness of a rib which suggests a musculoskeletal rather than a generalized arthritic process. And I don't see her complaining to Dr. Spoljaric or at least him recording the presence of generalized joint pain or swelling. And his physical examination doesn't indicate the presence of any of these. So if she had an inflammatory process involving her joints in August or in September I would expect by December we'd be seeing some physical manifestations or at least a reiteration on the part of the patient of these complaints.

Then we move on to the tests that he did. And we already talked about the bone scan that showed what looked like an osteoarthritic process, not a process of joint inflammation. She had a blood count and that showed a normal hemoglobin and normal hematocrit and a relatively low white blood count. And it showed an elevation of a sedimentation rate. She had an elevated

sedimentation rate many years earlier and the magnitude of the elevation was moderate.

MR. FRASURE: Which one?

A. 52 millimeters on December the 31st of 1997.

Q. You are going to describe that as moderate and of no clinical significance?

A. If we're talking about Wegener's granulomatosis, yes.

Q. But you don't have to necessarily jump to Wegener's granulomatosis to work the patient up for some kind of inflammatory process, some type of a vasculitis, do you?

A. Well, a sedimentation rate is a very nonspecific finding. If you know what the origin of the sedimentation rate is, it simply measures how quickly some blood cells fall to the bottom of the tube.

Q. Doctor, go ahead because I want to move on to another question and try to finish this deposition.

A. So I would expect that if she had vasculitis, active, involving the kidneys or of a substantial degree on December the 31st of 1997, that there would have been a reduction in

her hemoglobin and hematocrit. But any significant reduction in kidney function causes suppression of red blood cell formation and she has a normal hemoglobin and hematocrit. In addition to that in Wegener's or in many vasculitic processes the white blood count is high, not low. So I don't think that's a typical finding of an active vasculitis. In addition to that, she had the scan that we talked about.

Then from a clinical standpoint, she returns to see him in January and complains at that visit of a number of symptoms which in retrospect were likely related to Wegener's and these consisted of a sudden onset that is three days duration of cough, stuffy head, diffused myalgias and fever. The physical examination was nonspecific and Dr. Spoljaric presumed this might be due to influenza and initiated reasonable treatment for that. But when we see that she returns to him on March the 2nd of 1998 and says that she has continued to have this illness for a period of time along with shortness of breath on exertion and obvious wheezing, that suggests that she's got a

substantial problem there. When he examination her nose, he finds what looks like inflammation in the soft tissues which is probably active Wegener's granulomatosis. If we backup a little bit to the December of 1997 visit she had a chest x-ray. It was clear. And I would expect --

Q. Was that a PA and a lateral?

A. Well, let's see.

Q. Take a look. And when you look at it, is that the kind of chest x-ray that you would be taking if you were working up the patient to try to find whether or not there are any infiltrates associated with some type of vasculitis?

A. The PA view is the one that is usually used. The lateral is primarily a value in trying to decide whether the abnormalities you see on a frontal view are towards the front of the chest or toward the back of the chest.

Q. So that impression in your opinion was sufficient to rule out any type of infiltrates consistent with the vasculitis?

A. Yes, I think it is. And I think that it's especially adequate when you look at

her March of 1998 chest x-ray that shows the presence of infiltrates visible on the PA view.

Q. Any other clinical features because I want to move along.

A. Those are the significant ones. I mean she in mid January has a new set of complaints that she didn't have December 31 and it evolves.

Q. We talked about that. Anything else?

A. I think that's sufficient if you want to stay brief. I can look for more, but that gives you a flavor.

Q. I heard you loud and clear. Wegener's can effect the kidneys as the initial organ or the kidneys can be of the late onset of the systemic vasculitis, true?

A. Yes, but it's less common. You do see it in the kidneys first.

Q. My question was does it effect the kidneys early on?

A. That's right. You heard my answer.

Q. Well, answer my question because I have the prerogative since I paid you for your time to ask you questions unless you want to

return the check and you want to start asking me questions. Can we continue along?

A. Please.

Q. All right. Let's talk about vasculitis for a few minutes.

Vasculitis can be an inflammation of blood vessels, true?

A. That's what it is.

Q. It can be necrotizing?

A. Yes.

Q. It can lead to multi-system diseases?

A. Yes.

Q. Okay. When vasculitis effects the kidneys what usually happens?

A. There is usually -- well, it depends on the type of vasculitis.

Q. Okay.

A. Okay. It's not -- that's just a collection of many, many different diseases.

Q. What are the common manifestations when there is a vasculitis that effects the kidneys?

A. Which type of vasculitis are you talking about?

Q. You can't tell me what the common manifestations are of --

A. I'm telling you that different types of vasculitis have different types of manifestations. Vasculitis is a term which is about as specific as pneumonia and there are multiple underlying causes of pneumonia and they have different appearances, different prognoses.

Q. Vasculitis secondary to Wegner's granulomatosis.

A. Okay.

MR. FRASURE: There you go.

Q. Tell me what usually happens with the kidneys.

A. There is usually a rapid development of kidney inflammation of the glomerulonephritis which leads to abnormalities of kidney function such as BUN and creatinine and the presence of what is called an active urine sediment which contains basically the process of leakage of blood components through the damaged glomeruli into the renal tube and then into the urine. The abnormal components consisting of red blood cells and protein. And

there may be structural features such as casts which are aggregates of blood cells and protein also present.

Q. Okay. The type of vasculitis that you would expect to effect the kidneys caused by Wegener's granulomatosis is considered a rapidly progressive glomerulonephritis?

A. That is the characteristic pattern that is seen.

Q. But you can also have variant types of glomerulonephritis as the vasculitic component of Wegner's granulomatosis, true?

A. It may be the case, but one does not expect them to change from one type to another.

Q. When you talk about the rapidly progressive glomerulonephritis that connotes the development of renal failure it usually occurs in weeks to months as opposed to years, true?

A. Yes. And months being a month or two.

Q. Well, in the literature that I've looked at. Perhaps you can direct me to some literature that defines months in one or two as

opposed to months.

A. Okay. That's just my impression and that would be based upon the time from which the diagnosis is made or renal function abnormalities are discovered if it's untreated.

Q. Okay. If a dipstick is negative for urine?

A. For urine what?

Q. I'm sorry. If a dipstick is negative for protein?

A. Yes.

Q. Does that mean that 24-hour urine would also be negative?

MR. FRASURE: For protein?

A. No. You will see -- protein is normally shed in the urine in some quantity through the course of a day. But the amount of protein that implies the presence of significant kidney disease should be detected on a typical dipstick urine.

Q. Okay. Let's go back to my question. I said if a dipstick is negative for protein does that mean that a 24-hour urine would also be negative?

A. It will be negative for significant

protein uria from the standpoint of medical illness.

Q. Is it possible that Vickie could have had hematuria and not been leaking protein yet due to the necrotizing form of -- due to the necrotizing form of glomerulonephritis that she had -- in other words, protein not leaking out because of the concentric glomerulonephritis or the necrotizing fashion of the injury to the glomeruli?

A. I don't think so.

Q. Okay. Would you agree that the necrotizing -- that with the necrotizing form of glomerulonephritis hematuria develops prior to protein in the urine due to the effects of the scarring?

A. I'm not aware of that being a typical feature.

Q. So you would be surprised to see that in the medical literature?

A. As being more common than not, yes.

Q. But you not going to suggest that the literature did not report that as being a finding, that's not an aberration, but a finding that is -- that occurs from time to

time?

A. It an atypical finding if it occurs. I have not seen that it occurs. But if it does so, it would be considered unusual.

Q. And if you had done a microscopic urinalysis and it showed casts or dysmorphic red blood cells would that lead you to believe that kidney disease could be glomerular in origin?

MR. FRASURE: In August?

MR. MISHKIND: Correct.

A. If red cell casts were seen, yes.

Q. Would you see a reactive protein or ANCA or C-ANCA or P-ANCA in determining the etiology of glomerular disease at that time?

A. I don't think so.

Q. What tests would have done if you had done a microscopic urinalysis that showed casts or dysmorphic red blood cells?

A. I would have sent her to a nephrologist if I had seen that.

Q. Can you tell me what studies would have been the first line of attack from a nephrological standpoint upon referral?

A. I think probably a BUN and

creatinine measurement and probably a quantitative protein measurement and perhaps imaging studies of the kidneys and ultimately you would require a renal biopsy.

Q. Okay. Okay. You have said in your report that Dr. Cola met the standard of care in his treatment of Vickie Miglore?

A. Yes.

Q. Are there any aspects of his treatment on August 13th or August 27th that you would have done differently?

MR. FRASURE: Objection.

But go ahead.

A. I probably would have asked her about whether she had felt that her depression was present or recurring and would have recommended a trial of antidepressants on the 13th because a patient with depression and recurrent somatic symptoms of unclear cause will often have these related to the depression itself and may be significantly improved with treatment of antidepressants. On the 27th I don't think I would have done anything differently. I don't think that I necessarily would have sent the patient to a neurologist,

but I think it would have been reasonable to do.

Q. Would you have wanted to have prescribed an antibiotic?

A. I think so with the story of boils on the buttocks and face, yes.

Q. Would have been concerned that that's a condition that needed to be treated and antibiotics would be a reasonable initial step in the treatment?

A. Yes.

Q. And if antibiotics didn't resolve that would you then want to reexamine the patient in seven to ten days to see how the patient is doing?

A. Well, I would expect to hear from the patient if she is not doing well.

Q. Certainly it's incumbent upon the physician to communicate that to the patient in terms of how long to take the antibiotics and then to report back, true?

A. I don't generally put a time limit on it. I basically say that if you are having trouble let me know.

Q. In this situation none of this

information, antibiotics, referral to a neurologist was ever communicated to the patient. We have in the record an indication that a message was left on a machine and then there is a suggestion on September 1 that there may have been a telephone call. That's unclear. But no further efforts made to communicate with this patient, a patient who had called on the 27th very, very much concerned about her condition wanting to know what her problem was and wanting to talk to the doctor. What would you, Dr. Perlman, have done in order to make sure that important information was conveyed to the patient when she didn't return, presumably didn't respond to a message left on a machine?

A. Well, I'm not sure she didn't respond to the message left on the machine. I think there was further communication with the office.

Q. In what respect?

A. I think that, if I'm not mistaken, that she did return the call regarding the message on the machine. If in fact she didn't do so, then usually what we'll do is to

telephone the patient again. But it was my impression that there had been telephone contact with the office subsequent to the 27th of September.

Q. By, by Vickie?

A. Yes.

Q. Let's assume, just follow this hypothetical, that after the message was left on the machine that the only contact that Vickie had with the office was -- strike that.

Let's follow this hypothetical. After the message was left there was no communication of any information by the office to Vickie.

A. I think that that would not be sufficient. I would expect that there should be some communication after that message was called and if the message didn't get returned, the call -- if a call was not returned by Vickie subsequent to the 27th that another effort to contact her by telephone would have been appropriate within a few days time.

Q. And if someone couldn't reach Vickie, I mean there was no answer.

MR. FRASURE: A later call?

Q. In a later call, do you just stop at that point?

A. Generally speaking what happens in my office is that, that if there are reports which need to be conveyed to the patient they are not filed in the chart until there has been a transmission of that information. And that transmission may take weeks and if after several weeks time there has been no communication with the patient of any sort then we will usually send a note out in the mail.

Q. You consider yourself to be a reasonable and prudent practitioner, true?

A. Yes.

Q. Do you see any evidence in this case that Dr. Cola's office ever sent out a notification to the patient or left any further messages on a machine for the patient about reporting vital information?

A. No.

Q. When Vickie called for referrals to Dr. Torok and Dr. Schirack to the office, would you agree that those were additional opportunities --

A. Can I just go back for a second? I

mean I do want to make it clear that in Mrs. Miglore's deposition she says that she spoke with someone about the test results and it looks like on the 27th of August. So yes, it's my impression that there was some communication here.

Q. Let me tell you what the facts are so there is no misunderstanding. When she called she spoke to someone on the phone she was given whatever information she was given by that person on the phone and she wanted to speak to the doctor and wanted to talk to the doctor about whatever information was conveyed by that person. The doctor never called her back. The doctor gave information to his office manager about the sounds like infection, recommended augmentin and referred her to a neurologist and a message supposedly was left on her machine, a message that was never conveyed to Vickie from that date forward.

A. Well, let me backup. We're talking about the 27th of August on page 62.

Q. Yes.

A. And it says, as I read it, that someone called on the 27th of August. That you

called in on the 27th of August and spoke with someone in the office about the tests, about test results, does that seem right? Correct. So it would appear that Mrs. Miglore did telephone the office on the 27th of August and did speak to someone about test results and then --

Q. Doctor, let me ask you this because I can read the deposition as well as you can. Just hold up a second because I have heard the quotes and the references to the deposition.

A. Right.

Q. And we can spend a lot more time going over the lines in the deposition, but I'm going to represent to you to cut to the chase that number one, Dr. Cola's office has indicated that the receptionist is not to give out information about test results.

A. That's fine.

Q. And that Vickie's testimony has been, and while certain questions were asked in the deposition, I will represent to you that not only will she testify at trial but she's already indicated in a subsequent communication long before any lawsuit was filed that the only

information that she was provided over the phone was that there was some abnormality of the liver. That was the extent of it. There was no other information given, whether it was correctly given or not, there was no other information and she wanted to talk to the doctor because she was sick and she was getting worse. She wanted to know what was causing her problems. The doctor never got back to her. The only thing that we have in the record is a message was left on the machine. So presumptively the doctor wanted to communicate some information to her. With that backdrop and without quoting the deposition, if whatever information it was that Dr. Cola wanted to communicate to her, it was not communicated with the voice mail message because she didn't call back, would you agree that a reasonable and prudent physician wouldn't have just stopped with just leaving a message on the machine?

MR. FRASURE: Objection.

A. I don't think that leaving a message on the machine is adequate. I'm not sure that that's what took place. That's not

my impression, but.

Q. With all due respect, I've been --

A. Right.

Q. If that's the -- if that's your understanding of the facts, we'll explore that further, but I represent to you that if you are reading that then you are not, you are not reading it accurately. But be that as it may, let's move on.

We have another note that was purportedly made on September one that someone called and there was no answer. And then there is no indication in the record that anyone else told her she might have an infection, told her that she had to have a repeat of anything other than the liver tests, never told her about the referral to a neurologist. Would a reasonable and prudent practitioner, if reports needed to be conveyed to a patient, send out a card or make additional efforts to communicate to the patient?

MR. FRASURE: Objection. She didn't indicate that she was concerned and wanted to see the doctor.

A. My feeling was that the obligation

Dr. Cola has in this case for appropriate care is to notify the patient that there are abnormal tests and that follow-up is advisable and I think that that is sufficient.

Q. Okay.

A. And I think he did that.

Q. Wasn't the patient entitled to talk to the doctor about her concern over her worsening condition on August 27th?

A. By telephone?

Q. Well, let's start with the telephone.

A. No. I think that there are some doctors who say no.

Q. Your answer is no. Wasn't the patient then entitled to be seen by the doctor?

A. If the patient wished to be seen, yes.

Q. Okay. Is there any -- you recognize in her deposition that she said she called on three or four occasions wanting to talk to the doctor and wanted to schedule an appointment, true?

A. Well, she said that she had called, yeah. I don't recall the exact substance of

it, but she didn't schedule an appointment.

Q. She wanted to talk to the doctor and she wanted to schedule an appointment, that's what she testified to, true?

A. I'm not sure. I'd have to go back and read it.

MR. FRASURE: Objection.

Q. How soon do you stop making telephone calls to a patient if you want to get information to them? I'm sorry. You said about or three weeks you continue to make the calls?

A. Well, sporadically over two or three weeks and let them know by mail after three or four weeks.

Q. Okay. So I take it your opinion is going to be in this case that had he done a repeat urinalysis whether it was microscopic urinalysis or -- well, let's keep it microscopic urinalysis that it would have been -- it would not have led to a diagnosis of glomerulonephritis?

A. I don't believe so, not in August or September.

Q. What about in October?

A. I don't think in October.
Q. What about in November?
A. I don't think so.
Q. What about December?
MR. FRASURE: If done in December now?
MR. MISHKIND: Right.
A. I don't think so.
Q. All right. I asked you before, are there any other aspects of Dr. Cola's care in terms of how he handled things that you would have handled differently?
A. I don't think there are any substantive issues, no, with respect to those visits that we're talking about.
Q. Do you feel that Dr. Cola complied with everything that you have seen? That Dr. Cola complied with the standard of care throughout?
A. Yes.
Q. You have no criticism of his care in any respect?
A. No.
Q. You have no criticism of his office policy in any respect?

A. I have not seen a written policy if there is --

Q. Policies don't have to be in writing, do they?

A. Well, I haven't seen them explicitly stated anywhere.

Q. I curious. You have read over Dr. Cola's depo, but you have not looked over any of his personnel deposition, true?

A. If they are not listed in my report I didn't.

MR. FRASURE: Those just recently became available, I think.

Q. They have not been provided to you?

A. No.

Q. Okay. I think we have already talked about why you don't feel that his care contributed to her developing Wegener's because this is a condition that she was going to develop irrespective of what he did, the question is whether or not he could have diagnosed it sooner?

A. I don't think she had it at the time.

Q. But the issue is not did he cause

it, the issue is was it there to be diagnosed. I understand you are saying it was not there to be diagnosed.

A. Right.

Q. So that had he done all of the tests, hypothetically if one were to say that Dr. Cola should have done a microscopic urinalysis, then should have done a 24-hour urine, done a creatinine clearance or any of a number of other studies to determine whether or not there was any renal pathology, that back in August, September, October, November those tests would not have led to a diagnosis of Wegener's granulomatosis?

A. Not during those months, no.

Q. Okay. And you think that the earliest that a diagnosis was there to be made whether it was above or in compliance with the standard of care, whether it was beyond the call of duty if you will was sometime in January or February of 1998?

A. I think in January.

Q. Okay. But you don't fault Dr. Spoljaric in this case, true?

A. I have not looked at it as I say to

fault him or credit him.

Q. Okay. Are there any other opinions that you have as it relates to the standard of care that we have not talked about?

A. I'm not aware of any deficiencies and I think he did appropriate studies and that's the gist of it. I mean I'm not aware of any specifics right now.

Q. And the reason I ask you that is because the record is not very specific. It just says he complied with his standard of care and his care was not a proximate cause of any injuries so I want to find out in what respects you believe he complied with the standard of care. I want to find out whether or not I have missed any areas. I want to find out why it is you feel that he didn't violate the standard of care. I want to find out whether or not I have missed any of those areas.

A. Have you found that out yet?

Q. You tell me. Have I missed anything that you intend to testify to?

A. I can't recall you having asked me any questions that made me question the adequacy of standard of care since I wrote this

report. In other words, you have brought up a number of points and I have not had a reaction that any of those that would constitute a pattern of substandard care or instances of substandard care. I can't think of any off the top of my head beyond what we've discussed.

MR. FRASURE: I think he's also asking are there any other areas that we have not covered?

A. Well, that's kind of a hard question. That's sort of like when did you stop beating your wife. And I don't see any, when I look at this, I usually look for deficiencies, I haven't identified any.

Q. Would you agree that the earlier you diagnose glomerulonephritis caused by Wegener's granulomatosis the better?

A. In some cases, yes. In others, no.

Q. Can you tell me whether an early diagnosis of glomerulonephritis, an earlier diagnose of glomerulonephritis in Vickie Miglore's case secondary to her Wegener's would have given her a better prognosis?

MR. FRASURE: Object. Those are too vague.

A. Well, how much earlier I guess is the question.

Q. I asked you initially whether the earlier you diagnose glomerulonephritis caused by Wegener's granulomatosis the better.

A. I guess the answer would be it depends on what you mean by how much earlier.

Q. Okay. Well, statistically would you agree just as a general proposition that the less permanent damage to the glomeruli the better the long-term prognosis is for resumption of normal kidney function?

A. Well, I guess that the problem that I see with Wegener's granulomatosis as in many cases of vasculitis is that it is a disease which is not a self-limited one. That is, it doesn't go through a period of activity and then become permanently quiet. It tends to in a substantial number of cases be a chronic and recurring problem. So that one might find that if you diagnose the condition in let's say the year 2000 and treat it before renal failure has progressed you may avoid the need for dialysis at that point in time and may have a better BUN and creatinine let's say in March of 2000 than

had you not diagnosed it in January. Other than the nature of the condition is since it's chronic and subject to relapse that's not a guarantee that she will not have relapse in the future. In fact, that's more the rule than the exception. So that if you'll look at a long-term prognosis to say well what kind of shape will she be in in 2005 it's very hard to say that the diagnosis of two months earlier or three months earlier in the year 2000 will ultimately influence what kind of what shape she'll be in in 2000. It might influence what kind of shape she'll be in 2001. Does that answer your question?

Q. The way that you are going to answer the question, yes, it does. She is functioning with less than 50 percent of the kidney function that she had before she developed glomerulonephritis, true?

A. On renal function tests, yes.

Q. Okay.

A. Not in terms of her clinical -- not in terms of her functional ability to get around, in other words.

Q. Doctor, that's not my question.

Just answer my question.

A. All right. All right.

Q. She has 50 percent -- she has lost 50 percent of her kidney function, that doesn't mean that she's not able to get around.

A. Right. She's lost it in a laboratory sense and in a sense of examining the kidney.

Q. Okay. And as she gets older, she's going to continue to lose additional function of the kidney, is she not?

A. Everyone does.

Q. But not everyone starts out with the 50 percent of normal function, true?

A. Correct.

Q. She's at increase risk of having further complications because she has already lost 50 percent?

A. No. Actually, the major risk to her is the recurrence of Wegener's.

Q. Well, if she has a recurrence of Wegener's with 50 percent loss in kidney function she's at an increased risk of problems than someone else that has Wegener's that didn't develop kidney failure previously, true?

A. At any given point in time, yes.
Q. Okay.
A. Prior to the onset of end stage renal disease.
Q. Was she in end stage renal failure?
MR. FRASURE: When?
Q. Had she been in end stage renal failure at the time?
A. No.
Q. What's your definition of end stage renal failure?
A. It's irreversible permanent damage to the kidney that leads to uremia and requires dialysis or transplantation for restoration of adequate clearance of uremic toxins.
Q. She required dialysis, correct?
A. For a time.
Q. Why?
A. Because she had acute renal failure related to the rapidly progressive glomerulonephritis.
Q. What's her life expectancy?
A. I don't know. It's diminished from normal primarily because of the Wegener's.
Q. How is her life expectancy impacted

by virtue of reduced kidney function?

A. I think that's lesser of a risk to her longevity than the presence of this disease.

Q. You would certainly agree with me though statistically that people that have the degree of kidney disease that she has are at increased risk of additional morbidity and have lower life expectancies regardless of whether there is any flare-ups in the Wegener's?

A. Well, in the absence of Wegener's that basically she will -- if she never had Wegener's and had a creatinine of 2.8 at her age she would be at increased risk of developing end stage renal disease at some point in the future.

Q. As a consequence of that would you agree with me that more likely than not her life expectancy is lower than someone that doesn't have the degree of kidney disease that she has?

A. Yes. Although the major problem is not again the kidney disease. It's the fact that she has Wegener's that is going to lower her life expectancy.

Q. Okay. More likely than not she will have a flare-up in her Wegener's granulomatosis at some time in the future, true?
A. Yes.
Q. And more likely than not when she has a flare-up in her Wegener's granulomatosis it will impact her kidney function, true?
A. Yes.
Q. And more likely than not when she does have a flare-up in her Wegener's that effects her kidney function she's at increased risk of going into renal failure, true?
A. Yes.
Q. And she's at increased risk of developing other complications including hypertension related problems secondary to increased renal disease?
A. Right. That's as opposed to someone who has no renal involvement.
Q. Correct.
A. Or renal disease, yes, or doesn't have Wegener's.
Q. Okay. Are you able to give me an opinion to a probability as to what the likelihood is that she will need dialysis

and/or transplantation in the future given the fact that it's likely that she will have a flare-up in her Wegener's in the future?

MR. FRASURE: Do you mean chronic dialysis, permanent dialysis or just periodic?

Q. Just periodic dialysis.

A. I can't give you any likelihood to be considered reliable. It depends upon the nature of the underlying disease which is unpredictable. That it's -- it's guesswork to try to come up with some kind of a figure.

Q. So I take it it would be equally guesswork to say whether or not she's likely to going to require chronic dialysis or transplantation?

A. It's guesswork. If she lives long enough she may do that.

Q. More likely than not?

A. More likely than not. But living long enough, at some ripe age it's very hard to tell.

Q. Well, she's 50 years old now.

A. Right.

Q. Normally she would have a life expectancy according to Uncle Sam of somewhere

around today age 85, so about a 35 year life expectancy?

A. Okay.

Q. Given her current morbidity, without a flare-up up in Wegener's, if it just stays quiescent she has got a reduced life expectancy with what she's got right now, true?

A. I don't know. I have patients with creatinines in the 20 to 30 range who with medical management have shared what appears to be fairly stable functioning over a period of a decade or more. That's because we have drugs now that are able to retard the progression of the aging process or the stress on the kidney from prior damage. So I think the natural history of the disease has been modified in recent years with the use of a number of these agents. It's hard for me to say if we're talking about her living to 80 that she couldn't live to 80 without end stage renal disease. I'm not going to say one way or the other. But I'm saying that we have modified the history of that and that the prior prognosis that might have been there five or ten years ago just on the basis of a normal

kidney function is not as grim has perhaps it used to be.

Q. Putting aside all that we have talked about I just want to come back to a couple of basics and then we're done. You agree with me that her urine needed to be retested at some time to comply with the standard of care, correct?

MR. FRASURE: Objection. We've been over this so many times.

A. Yes.

Q. Okay. And you agree with me that it was below the standard of care not to repeat the urine at some time in the future?

MR. FRASURE: Objection. We've been over all of these explanations already.

Q. Correct?

A. It was not a deficiency on Dr. Cola's part, no. No, I don't agree with that.

Q. The reason you say it was not a deficiency on his part was why?

A. Because she did not return to his office or care for follow-up.

Q. Again, you are giving Dr. Cola the

benefit of the doubt that he didn't fail to give her the opportunity? In other words, if he failed to return calls, if the office failed to give an appointment to her and if she was not advised that she needed to have a repeat urine hypothetically would be a violation of standard of care?

MR. FRASURE: Objection. Very repetitive.

Go ahead.

A. If he was unwilling to see her back again that would be a violation of standard of care.

Q. If he was unwilling or didn't make what you would consider to be reasonable efforts for accommodations to see her again, that would be a violation of the standard of care, true?

MR. FRASURE: Objection.

A. Well, I think the question is what do you consider to be reasonable accommodations? And if she attempted to schedule an appointment and was refused that opportunity, then that would be unreasonable. If she for whatever reason did not attempt to

or chose not to schedule an appointment then that's not a deficiency on his part.

Q. Okay. And that becomes a factual issue?

A. Sure.

Q. Okay. All right. I have nothing further for you.

A. Okay.

MR. FRASURE: We'll read. Thank you.

(Signature not waived.)

(Deposition concluded at 8:39 p.m.)

CERTIFICATE

The State of Ohio,)
SS:
County of Cuyahoga.)

I, Barbara J. Watowicz, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, MEADE A. PERLMAN, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 24th day of October, 2000.

Barbara J. Watowicz

Barbara J. Watowicz, Notary Public within and for the State of Ohio

My commission expires March 20, 2002.