

Last Name	Reilman
First Name	Maude A.
Specialty	Nephrologist
Party	Plaintiff <input checked="" type="checkbox"/> Defendant <input type="checkbox"/>
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1 IN THE COURT OF COMMON PLEAS
2 OF SUMMIT COUNTY, OHIO

3
4 VICKIE MIGLORE, et al,
5 Plaintiffs,

6 vs. Case No. 99CV030973

7 DAVID COLA, M.D., et al,
8 Defendants.

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

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1 APPEARANCES:

2

3 On behalf of the Plaintiffs

4 Becker & Mishkind, by

5 HOWARD D. MISHKIND, ESQ.

6 Suite 660, Skylight Office Tower

7 1660 West 2nd Street

8 Cleveland, Ohio 44113

9 (216) 241-2600

10 On behalf of the Defendants

11 Buckingham, Doolittle

12 & Burroughs, by

13 MARK D. FRASURE, ESQ.

14 4518 Fulton Drive, N.W.

15 Canton, Ohio 44753

16 (800) 686-2825

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2 (Thereupon, Plaintiff's Deposition
3 Exhibits 1 and 2 were marked for
4 purposes of identification.)

5 ~ ~ ~ ~ ~

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

11 EXAMINATION OF MEADE A. PERLMAN, M.D.
12 BY MR. MISHKIND:

13 Q. State your name, please.

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

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

21 A. Yes.

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

24 A. Yes.

25 Q. Is it current and updated or are

1 there any additions that need to be made?

2 A. There are no additions.

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

10 A. No, that was provided to me.

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

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

18 Q. Okay.

19 A. Okay.

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

23 ~ ~ ~ ~ ~

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

1 identification.)

2 ~ ~ ~ ~ ~

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

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

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

13 A. Sure.

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

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

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

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

25 Okay. Then I did see those before

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

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

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

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

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

21 A. Yes, sir.

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

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

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

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

9 A. Yes.

10 Q. Okay. Now, in your report you have
11 identified a number of items that you reviewed
12 in preparation for your report dated September
13 25th. We've talked about Dr. Torok's records
14 which you believe you saw?

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

17 Q. All right.

18 A. Yes.

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

21 A. No.

22 Q. Let me finish, doctor, please.

23 A. I'm sorry.

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

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

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

8 Q. Okay.

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

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

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

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

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

25 Q. Can you tell me what else you have

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

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

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

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

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

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

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

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

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

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

18 A. Yes.

19 Q. What is that based upon?

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

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

25 A. About ten.

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

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

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

11 A. Not precisely, no.

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

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

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

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

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

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

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

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

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

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

18 A. Yes.

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

22 A. No, sir.

23 Q. It's not?

24 A. No, sir.

25 Q. Tell me why you take issue with

1 that.

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

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

6 A. No.

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

12 A. Not under ordinary circumstances.

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

17 A. No.

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

20 A. Not on a regular basis.

21 Q. You're an internist, correct?

22 A. Yes, sir.

23 Q. Board certified in internal
24 medicine?

25 A. Yes.

1 Q. You recognize Harrison's as a
2 reliable and authoritative text in the area of
3 internal medicine, true?

4 A. No.

5 Q. What text do you own in the area of
6 internal medicine?

7 A. I own no text in internal medicine.

8 Q. Okay. What journals do you
9 subscribe to?

10 A. The Journal of the American Medical
11 Association. The New England Journal of
12 Medicine. The Lancet. The Annals of Internal
13 Medicine. The Archives of Internal Medicine.
14 The Mayo Clinic Proceedings. The Journal of
15 American Geriatric Society. Those are the ones
16 that come to mind immediately.

17 Q. You do not own Harrison's?

18 A. No.

19 Q. You don't own any textbooks
20 relating to the area of internal medicine?

21 A. No.

22 MR. FRASURE: You include his
23 clinic, too? Do you mean him personally or the
24 office that he's with here?

25 MR. MISHKIND: Well, let's start

1 with him personally.

2 A. No.

3 Q. You have Harrison's available to
4 you in the clinic, don't you?

5 A. No.

6 Q. You don't. Do you acknowledge that
7 Harrison's is one of the leading textbooks in
8 the area of internal medicine?

9 A. Yes.

10 Q. Okay.

11 A. In terms of popularity.

12 Q. It's just not one that you own or
13 that you refer to from time to time, true?

14 A. In general circumstances that's
15 correct.

16 Q. Have you done any research at all
17 in the medical literature in connection with
18 any aspects of the opinions that you hold in
19 this case?

20 A. Yes.

21 Q. What have you researched?

22 A. I read the chapter on Wegner's
23 granulomatosis in Scientific America Medicine.

24 Q. What else, if anything?

25 A. I attempted a Med Line search on

1 some aspects of Wegener's granulomatosis.

2 Q. You attempted it?

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

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

7 A. Along with additional factors.

8 Q. What were the additional factors?

9 A. Hematuria.

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

13 A. That's right.

14 Q. And this was a Med Line?

15 A. This was Med Line going back to
16 1995.

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

19 A. I believe that's all.

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

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

1 that I would necessarily concur with, but in
2 general.

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

5 A. Yes.

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

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

11 Q. So between 12 and 24 occasions?

12 A. Roughly.

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

16 A. Yes.

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

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

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

1 support of allegations made by a patient?

2 A. Once.

3 Q. And was that the Knuth case?

4 A. Yes.

5 Q. Okay. Plaintiff's counsel in that
6 was Mr. Ockerman, true?

7 A. I think he was a co-counsel with an
8 attorney in Phoenix.

9 Q. You review cases on what frequency
10 per year?

11 A. That really varies according to how
12 frequently I'm asked. Probably within the past
13 year I have looked at six or eight which I
14 would say is the most ever.

15 Q. Besides this case currently how
16 many other cases are you serving as an expert
17 for the Buckingham, Doolittle firm?

18 A. I can think of one other case.

19 Q. You have been doing medical/legal
20 work for the last ten or 11 years?

21 A. I'd say 15 years or so.

22 Q. 15 years. The 12 to 24 cases or 12
23 to 24 times that you have been deposed, you
24 have been serving as a standard of care expert
25 providing testimony as to whether a particular

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

3 A. Among other issues, yes.

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

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

9 MR. MISHKIND: In terms of
10 testifying.

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

13 MR. MISHKIND: Right.

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

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

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

22 MR. FRASURE: This year.

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

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

5 Q. For a past and current Buckingham?

6 A. Then we're up over half.

7 MR. FRASURE: You can include
8 those.

9 Q. For example, people like Mr.
10 Shelbert?

11 A. Right.

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

14 A. Yes, yes.

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

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

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

1 A. No.

2 Q. The only time you have testified in
3 deposition as a plaintiff's expert was in the
4 Knuth case?

5 A. Yes.

6 Q. Are you currently scheduled to give
7 deposition testimony in any other cases in the
8 foreseeable future?

9 A. No.

10 Q. When were you last deposed?

11 A. Let me think back. I think it was
12 sometime in May. I'm trying to remember if
13 there was one that took place over the summer.
14 I recall an expert deposition in May.

15 Q. Who deposed you in May?

16 A. It was an attorney from either
17 Cleveland or the far eastern suburbs. And I
18 don't remember his name.

19 Q. What attorney were you retained by
20 or some similar term?

21 A. This was from Reminger & Reminger,
22 I believe. I think it was Ms. Sandacz and
23 Ingrid Kinkopf-Zajac. If I'm remembering it
24 correctly. It was a difficult hyphenated name.
25 I think the two were working on the case

1 together.

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

4 A. Dr. Murphy.

5 Q. John Murphy?

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

11 Q. Who was plaintiff's counsel?

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

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

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

20 Q. Is he a Canton, Ohio doctor?

21 A. Yes.

22 MR. FRASURE: Howard, for
23 clarification.

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

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

3 MR. FRASURE: That's been resolved.

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

7 A. On two occasions.

8 Q. Are you sure?

9 A. Yes.

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

12 A. No.

13 Q. Have you ever talked to Dr. Cola?

14 A. No.

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

17 A. No.

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

20 A. No.

21 Q. Dr. Schirack, Dr. Torok?

22 A. No.

23 Q. Dr. Spolarjic?

24 A. No.

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

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

5 A. Perhaps three or four.

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

8 MR. FRASURE: Objection.

9 Go ahead.

10 MR. MISHKIND: You can show a
11 continuing line.

12 MR. FRASURE: Okay.

13 A. Three times.

14 Q. Are you currently a defendant?

15 A. No.

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

24 A. True.

25 Q. Were you asked to opine or to

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

4 A. No.

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

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

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

20 A. Neither breached nor met the
21 standard of care.

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

24 A. I have not attempted to formulate
25 any.

1 Q. Okay.

2 A. I have not been asked to.

3 Q. Okay. Fair enough. That was not
4 your assignment?

5 A. Right.

6 Q. Okay. Let's talk about Wegener's
7 and talk about Vickie Miglore. First
8 Wegener's. Do you have any Wegner's
9 granulomatosis patients within your patient
10 population?

11 A. Not alive.

12 Q. How long have you been in practice?

13 A. Since 1977.

14 Q. How many of your Wegner's patients
15 have died?

16 A. One.

17 Q. How many Wegener's patients have
18 you had?

19 A. One.

20 Q. How long ago was it that you had a
21 Wegner's patient about?

22 A. Five years ago.

23 Q. Male, female?

24 A. Female.

25 Q. Age?

1 A. Approximately 65.

2 Q. Onset of Wegener's at what age?

3 A. Approximately 64.

4 Q. What organ system was first
5 implicated?

6 A. Her lung.

7 Q. Did she develop renal failure?

8 A. What do you mean by renal failure?

9 Q. Did she develop kidney involvement
10 secondary to Wegener's?

11 A. Yes.

12 Q. What was the affect on her kidneys?
13 Did she go on to develop renal dysfunction?

14 A. She developed renal dysfunction on
15 laboratory studies.

16 Q. Did she require dialysis?

17 A. No.

18 Q. What was her kidney function? How
19 impaired?

20 A. I think her peak creatinine was
21 about four.

22 Q. The major manifestation was upper
23 and lower respiratory fracture?

24 A. Yes.

25 Q. And did she die of complications of

1 the Wegener's or complications of other medical
2 conditions?

3 A. Complications of the Wegener's.

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

7 A. Yes.

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

11 A. I diagnosed with the assistance of
12 others.

13 Q. Who did you call in?

14 A. I think a pulmonologist was
15 involved.

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

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

21 Q. What were her clinical signs and
22 symptoms?

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

1 led to respiratory failure.

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

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

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

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

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

16 A. Typically, yes.

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

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

25 Q. When one suspects a patient having

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

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

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

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

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

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

23 Q. And this is what happened with your
24 patient?

25 A. Yes.

1 Q. Okay. And she was started on
2 Cytoxans and immunosuppressant therapy or
3 steroids?

4 A. Yes.

5 Q. At the time of her diagnosis,
6 Dr. Perlman, she had some renal involvement but
7 was not in renal failure?

8 A. Yes.

9 Q. And when she was treated with the
10 Cytoxans and the Prednisone, did she stabilize
11 with regard to her renal function?

12 A. Her renal function stabilized after
13 a time.

14 Q. Okay. Do you agree or disagree
15 that blood is a classical finding in Wegener's
16 granulomatosis when there is renal involvement?

17 MR. FRASURE: Blood in the urine?

18 MR. MISHKIND: Well, ultimately it
19 comes out, but.

20 MR. FRASURE: Okay. Fair enough.

21 A. Not an isolated finding.

22 Q. I'm not saying isolated, but
23 hematuria is a classical finding of Wegener's
24 granulomatosis when there is renal involvement?

25 A. With other findings in the urine,

1 yes.

2 Q. Okay. Do you agree or disagree
3 that you can't rule out the possibility that
4 blood in Vickie Miglore's urine in August of
5 1997 -- let me rephrase.

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

14 MR. FRASURE: Objection.

15 Go ahead.

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

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

1 certainty rule it in or rule it out?

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

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

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

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

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

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

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

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

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

3 Q. And what do you base that on?

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

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

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

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

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

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

25 A. Because on a statistical basis most

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

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

6 A. No.

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

9 A. No.

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

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

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

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

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

1 from the kidney.

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

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

11 A. It's the same.

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

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

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

1 presenting feature without protein?

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

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

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

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

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

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

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

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

10 MR. MISHKIND: Yes.

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

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

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

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

22 A. Well, nephritis is a histologic
23 diagnosis.

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

1 A. That requires tissue.

2 Q. Okay. What about
3 glomerulonephritis?

4 A. The same is true.

5 Q. Well, if you have blood in the
6 urine, what signs and symptoms do you need to
7 see to cause you to think this is urinary tract
8 infection versus renal disease or renal
9 dysfunction?

10 MR. FRASURE: Just blood in the
11 urine.

12 Q. Without evidence of protein,
13 without evidence of leukocytes, without ketones
14 and without glucose?

15 A. Are you saying that this would be
16 more likely renal than some other source and
17 glomerulonephritis specifically as opposed to a
18 renal cyst?

19 Q. I guess what I'm saying is as a
20 clinician, as a reasonable and prudent
21 clinician, what signs and symptoms would you
22 expect to see or would you need to see in a
23 patient that also had a three plus blood on
24 their urine dipstick to be thinking is this
25 urinary tract in origin or is this renal

1 dysfunction?

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

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

8 Q. All right.

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

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

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

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

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

25 Q. The majority being more than 50

1 percent?

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

4 Q. Can you be anymore precise?

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

8 Q. What books?

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

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

13 A. Yes.

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

17 A. It's uncommon.

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

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

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

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

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

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

12 A. No.

13 Q. You would not agree with that
14 statement?

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

17 Q. What do you mean by the word
18 benign?

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

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

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

3 Q. Under what circumstances would it
4 not be benign?

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

11 Q. Such as?

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

18 Q. Such as?

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

21 Q. What about vasculitis?

22 A. Well, vasculitis is a form of
23 inflammation.

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

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

4 MR. FRASURE: Blood only now?

5 MR. MISHKIND: Yes.

6 A. I refer patients to a urologist.

7 Q. Okay.

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

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

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

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

18 A. Yes.

19 Q. You don't refer to a nephrologist?

20 A. No.

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

1 urine from August 13th?

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

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

6 MR. FRASURE: Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

22 Q. Your read of this case is that he
23 had her get an ultrasound which was done on the
24 26?

25 A. There is a report on the ultrasound

1 saying there is a prominence of bile duct.

2 Q. Where was the ultrasound done based
3 upon your review?

4 A. I have to go back and find it.

5 Q. Do you know as you sit here right
6 now?

7 A. I have to go find it. I don't like
8 to guess.

9 Q. I'm not suggesting that you guess.

10 A. That's why I'm saying if I look it
11 up, I can tell you.

12 Q. Well, obviously, I want to know
13 what information you have as an expert in the
14 case, so sure.

15 A. On August the 21 she had an
16 ultrasound of the abdomen. Of the upper
17 abdomen. And that was the date that it was
18 performed.

19 Q. Okay. And do you know where that
20 was performed at?

21 A. At Barberton Citizens Hospital.

22 Q. Okay. Now, did she have any
23 leukocytes in her urine on the urine dipstick?

24 A. No.

25 Q. That would suggest against

1 infection, would it not?

2 MR. FRASURE: All infection or
3 urinary tract?

4 A. What kind of infection are you
5 talking about?

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

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

10 Q. Okay.

11 A. Lower being the bladder or the
12 urethra.

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

16 A. That's correct.

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

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

1 that the two have good sensitivity.

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

4 A. No.

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

7 A. Yes.

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

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

14 Q. Based on what?

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

19 Q. Based upon a urine dipstick?

20 A. Have you heard what I said?

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

23 A. I said you can infer that.

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

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

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

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

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

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

1 been ordered?

2 A. Correct.

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

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

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

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

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

15 A. No, not in the records.

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

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

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

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

1 it.

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

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

9 Q. Tell me why.

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

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

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

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

19 A. Number one, as soon as possible?

20 Q. Right.

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

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

25 A. Because hematuria is often a

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

10 Q. Okay.

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

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

17 A. Yes.

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

1 office visit with Dr. Cola?

2 A. No.

3 Q. Why?

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

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

14 A. No.

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

17 A. Yes, as a working diagnosis.

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

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

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

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

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

9 Q. All right. What was the working
10 diagnosis?

11 A. An infection.

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

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

16 MR. MISHKIND: Yes.

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

19 Q. Boils --

20 A. That's what they are to me.

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

23 A. They are not a common feature, no.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 cervical pain with muscle tension headache.

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

8 A. Yes.

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

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

15 Q. Well, I guess what you are, what
16 you are taking is the 13th as well as now the
17 additional symptoms that are presented on the
18 27th, true?

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

23 Q. Okay. Tell me.

24 A. Go through that with you?

25 Q. Yes.

1 A. Let's go to the note of August the
2 13th. First complaint. Has had headache of
3 neurologic origin. Generalized weakness.
4 Nonspecific. May be neurological. Felt arm
5 tingle and of neurological origin.

6 He performs a physical exam which
7 doesn't reveal any clear cut explanation and
8 has not really performed a neurologic exam.
9 Comes up with a working diagnosis of cervical
10 pain with muscle tension headache and some
11 generalized pain. Prescribes a series of
12 physical maneuvers to see if he can alleviate
13 the pain consisting of manipulations and hot
14 packs. Also a trial of a muscle relaxants.
15 And performs a number of studies to look for a
16 metabolic explanation for the problems. These
17 tests come back. She reports to him on the
18 27th with complaints you have enumerated. And
19 in my mind that would again imply the
20 possibility of infection given the presence of
21 boils and a persistence of the complaints that
22 were enumerated at the visit of the 13th. And
23 having done the evaluation and the trial of
24 treatment that was performed back on the 13th,
25 and having the benefit of the ultrasound test,

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

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

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

11 Q. Yes.

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

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

24 A. True.

25 Q. Vickie was never even communicated

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

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

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

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

13 Q. No antibiotics were ever ordered or
14 prescribed for Vickie Migllore, were they?

15 A. Was the Augmentin not prescribed
16 for her?

17 Q. You tell me, doctor.

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

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

25 A. That I don't know.

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

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

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

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

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

18 A. Not directly, no.

19 Q. Vickie Miglore was never given an
20 appointment --

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

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

1 A. I don't believe the office
2 scheduled one.

3 Q. A microscopic urinalysis was never
4 scheduled, correct?

5 A. Correct.

6 Q. The records don't reflect a
7 microscopic urinalysis was within the plan of
8 treatment at any time while Dr. Cola was her
9 physician, true?

10 A. That's right.

11 Q. And from all that you have reviewed
12 can we agree that Vickie Miglore was never told
13 by Dr. Cola or his office that she had blood in
14 her urine?

15 A. Correct.

16 Q. Can we agree that any patient,
17 whether it's Vickie Miglore, Perlman or Howard
18 Mishkind that if you have blood in the urine
19 you are entitled to know about that?

20 A. I think that you are entitled to
21 know about it, yes.

22 Q. And you are entitled to know about
23 it and should know about it especially if there
24 are additional tests that need to be done to
25 determine whether or not the blood in the urine

1 is benign or otherwise, true?

2 A. Yes.

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

8 A. Read the symptoms to me again.

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

14 A. Yes.

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

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

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

24 A. Kidney stone or urinary tract
25 infection.

1 Q. What about nephritis?

2 A. No, I don't think that's a typical
3 symptom.

4 Q. Would you rule out nephritis based
5 upon that?

6 A. I wouldn't begin to think of
7 nephritis.

8 Q. You wouldn't rule it out though
9 based upon those symptoms?

10 A. I don't consider those symptoms to
11 be representative of nephritis.

12 Q. Okay. If the patient came to your
13 office with these symptoms is it your
14 suggestion that part of your differential would
15 not include kidney disease?

16 A. First of all, I don't necessarily
17 formulate the differential. I think we
18 discussed that earlier.

19 Q. Right.

20 A. And secondly, intrinsic renal
21 disease would not be a significant component of
22 those symptoms.

23 Q. On Dr. Cola's record for the plan
24 he had a UA marked down on his record on August
25 13th?

1 A. Can I go back to that other
2 question? I would consider cancer in the
3 kidney as a potential symptom.

4 Q. Okay.

5 A. Okay.

6 Q. Anything else you wanted to add?

7 A. No. That's okay.

8 Q. Dr. Cola had a UA marked down or
9 urinalysis on August 13th as part of his plan?

10 A. Yes.

11 Q. He did a urine dipstick?

12 A. Yes.

13 Q. That's a different creature, is it
14 not?

15 A. Well, it's a different creature.
16 The question is by his writing it in this way
17 is that what he had intended to have done? I
18 suspect it was.

19 Q. Why?

20 A. That's how the tests are performed
21 in many practitioners' offices.

22 Q. When he sent Vickie to Barberton
23 Citizens Hospital do you know whether he had
24 the information about the three plus blood from
25 the dipstick?

1 A. At what time are we talking about?

2 Q. Prior to her leaving the office.

3 A. I don't think he had that
4 information.

5 Q. And what do you base that on?

6 A. Because I believe what he did was
7 he wrote the order for the nurse to do the
8 studies and she did the studies and gave her
9 orders to take off to Barberton Citizens for
10 the studies aside from the urinalysis which was
11 probably after he saw the patient.

12 Q. Well, would it surprise you to know
13 that number one, the urinalysis was done early
14 in the visit and after she was seen by Dr. Cola
15 she had high velocity treatments and was at the
16 doctor's office for a period of time such that
17 the urinalysis, the blood, the urine dipstick
18 results were in the chart and were available
19 for Dr. Cola long before she had left?

20 A. Are you saying that she gave the
21 urine sample or are you saying that she
22 actually had the test? The tech had actually
23 done the test and put the results on the chart?

24 Q. Let's assume that she gave the
25 sample and that the results were posted in the

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

6 A. Yes.

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

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

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

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

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

22 A. Yes.

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

25 A. I think in a general sense that

1 they are normal or not normal.

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

6 A. I typically do when time permits.

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

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

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

14 What are you looking for?

15 A. His office notes. The handwritten
16 notes.

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

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

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

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

14 A. Well, I can't. No. Other than
15 that, I don't see that he spoke with her. I
16 can't conclude whether he did or didn't on the
17 20th based on what I can read here.

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

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

25 Q. Can the kidneys compensate when

1 only a small portion of glomeruli are damaged?

2 A. What do you mean by compensate?

3 Q. Can the kidneys perform their
4 function when only a small portion of the
5 glomeruli are damaged?

6 A. Yes.

7 Q. In early kidney disease are BUN and
8 creatinine always elevated?

9 A. What do you mean by early kidney
10 disease?

11 Q. When there is a small portion of
12 glomeruli damaged.

13 A. When there is disease of clinical
14 significance they'll become abnormal.

15 Q. In early kidney disease BUN and
16 creatinine is not elevated until there is some
17 evidence of permanent kidney damage, true?

18 A. No.

19 Q. When do you start seeing elevation
20 of the BUN and creatinine?

21 A. The minute the functional capacity
22 of kidneys is impaired for any variety of
23 reasons. When you talk about functional, I'm
24 presuming you are talking about whether the
25 kidney is able to function to a point of

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

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

14 A. In what area?

15 Q. In any area of her body.

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

18 MR. MISHKIND: Right.

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

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

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

25 A. The abnormalities of the liver

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

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

6 A. Those specific tests are considered
7 to be abnormal.

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

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

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

13 A. It can be.

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

16 A. Not ordinarily.

17 Q. What is LDH normally indicative of?

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

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

23 A. Often you would.

24 Q. Okay.

25 A. Yes.

1 Q. And what would you look to?

2 A. I would look to a presence of
3 absence of fever from a symptoms standpoint.
4 Presence or absence of localized symptoms
5 related by the patient. And I would look to
6 abnormalities of physical findings if I
7 actually performed an exam at the time that the
8 tests were obtained. I would look at the blood
9 count for evidence of either a high or a lower
10 white blood count or evidence of a change in
11 the differential count of the neutrophils,
12 lymphocytes or monocytes.

13 Q. Was there any evidence of infection
14 based upon the white blood count?

15 A. Not as of the 21st of August.

16 Q. Again going back to the 26th.
17 Other than what you have identified as
18 potential signs of infection, can we agree that
19 normally you would be looking to elevations in
20 the white blood count as being the laboratory
21 tests that would give you the most valuable
22 information as to whether or not the patient
23 has an infection?

24 A. Well, let's decide on what date
25 we're talking about trying to make that

1 determination that the patient has an infection
2 or not.

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

5 A. Well, the results come back on the
6 26th I believe but they were obtained on the
7 21th.

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

11 A. Yes.

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

16 A. Among other things, yes.

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

20 A. It would be a significant one.

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

24 A. On the 21st of August.

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

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

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

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

9 A. No.

10 Q. The ultrasound of the abdomen was
11 essentially normal?

12 A. No, it showed changes.

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

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

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

23 A. No.

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

1 results on August 26th?

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

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

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

12 Q. Were they normal and of no clinical
13 significance?

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

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

19 A. Yes.

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

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

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

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

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

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

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

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

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

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

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

13 A. Typically an IVP, intravenous
14 pyelogram.

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

17 A. No.

18 Q. Was Vickie Miglore ever referred to
19 a urologist?

20 A. No.

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

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

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

9 Q. Tell me why?

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

1 begin to suggest vasculitis as being a likely
2 condition.

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

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

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

15 A. If possible, yes.

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

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

25 Q. Well, when did he ultimately

1 conclude his evaluation?

2 A. He never did because she left his
3 practice.

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

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

9 Q. That's at the end of December?

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

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

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

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

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

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

7 A. No. I think if we look at the
8 records there are notes here that say on the
9 26th that he wanted to recheck the enzymes and
10 also on the 27th that he wanted to prescribe
11 augmentin and that he was referring her to a
12 neurologist. So I think that there were
13 recommendations that he was making.

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

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

1 grabbing her deposition transcript now, true?

2 A. Well, I'm not grabbing it.

3 Q. You are seizing the moment.

4 However, you also know that she testified that
5 she called on three or four occasions after
6 August 27th wanting to talk to the doctor,
7 wanting to get the results of her tests and
8 that Dr. Cola did not get on the phone and
9 Dr. Cola never called her back, is that true?

10 A. I'm aware that she said something
11 to that effect.

12 Q. And she testified that she had
13 difficulty with getting referrals to other
14 doctors done in a timely basis.

15 A. I don't recall that specifically,
16 but I won't deny that.

17 Q. You are also aware that she was in
18 contact with Dr. Cola's office on at least two
19 or three occasions where there are notes made
20 in the chart with her calling for referrals to
21 two specialists, Dr. Torok and Dr. Schirack,
22 true?

23 A. Yes.

24 Q. Yet no efforts were made on those
25 dates to communicate with her that we've got

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

7 A. That would appear to be the case.
8 Although I see something here about needs
9 referral faxed and test results faxed on the
10 24th of October.

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

24 A. Not for the gastroenterologist.

25 Q. Certainly for the primary care

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

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

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

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

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

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

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

18 A. No.

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

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

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

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

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

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

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

15 A. That was my impression.

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

18 A. Yes.

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

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

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

20 Q. You said the 7th. Did you mean the
21 11th?

22 A. The 11th. I'm sorry.

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

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

4 A. I was not aware of that.

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

7 A. No.

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

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

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

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

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

10 A. There is clinical evidence means
11 physical findings?

12 Q. Yes.

13 A. Yes.

14 Q. Okay.

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

17 Q. I understand.

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

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

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

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

5 Q. Okay.

6 MR. FRASURE: Who is he now?

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

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

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

16 Q. What about a bone scan?

17 A. A bone scan can do that.

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

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

25 Q. Why?

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

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

5 A. Okay. Well, the nerve conduction
6 was normal. So obviously that's not evidence
7 for either a neurological problem or a
8 vasculitis if you are going to contend that's
9 vasculitis-produced abnormalities. But we'll
10 go to Dr. Spoljaric's records and basically the
11 bone scan showed increased uptake in the mid to
12 lower thoracic spine and knees most likely due
13 to degenerative arthritis. That's not
14 inflammatory arthritis. A bone scan might show
15 signs of inflammatory arthritis, but in her
16 case it did not. That was done on January the
17 7th of 1998.

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

21 A. Yes.

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

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

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

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

9 A. During the active period of
10 necrosis.

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

14 A. Sometime after mid January of 1998.

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

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

20 Q. Well, that's a huge --

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

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

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

25 Q. Please, that's what my mind can

1 handle.

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

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

1 that she has related to Dr. Spoljaric on the
2 30th of December that she's got symptoms of
3 vasculitis or Wegener's granulomatosis.

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

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

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

3 MR. FRASURE: Which one?

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

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

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

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

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

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

22 A. So I would expect that if she had
23 vasculitis, active, involving the kidneys or of
24 a substantial degree on December the 31st of
25 1997, that there would have been a reduction in

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

11 Then from a clinical standpoint,
12 she returns to see him in January and complains
13 at that visit of a number of symptoms which in
14 retrospect were likely related to Wegener's and
15 these consisted of a sudden onset that is three
16 days duration of cough, stuffy head, diffused
17 myalgias and fever. The physical examination
18 was nonspecific and Dr. Spoljaric presumed this
19 might be due to influenza and initiated
20 reasonable treatment for that. But when we see
21 that she returns to him on March the 2nd of
22 1998 and says that she has continued to have
23 this illness for a period of time along with
24 shortness of breath on exertion and obvious
25 wheezing, that suggests that she's got a

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

8 Q. Was that a PA and a lateral?

9 A. Well, let's see.

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

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

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

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

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

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

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

9 Q. We talked about that. Anything
10 else?

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

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

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

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

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

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

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

3 A. Please.

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

6 Vasculitis can be an inflammation
7 of blood vessels, true?

8 A. That's what it is.

9 Q. It can be necrotizing?

10 A. Yes.

11 Q. It can lead to multi-system
12 diseases?

13 A. Yes.

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

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

18 Q. Okay.

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

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

24 A. Which type of vasculitis are you
25 talking about?

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

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

10 Q. Vasculitis secondary to Wegner's
11 granulomatosis.

12 A. Okay.

13 MR. FRASURE: There you go.

14 Q. Tell me what usually happens with
15 the kidneys.

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

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

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

8 A. That is the characteristic pattern
9 that is seen.

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

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

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

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

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

1 opposed to months.

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

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

8 A. For urine what?

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

11 A. Yes.

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

14 MR. FRASURE: For protein?

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

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

25 A. It will be negative for significant

1 protein uria from the standpoint of medical
2 illness.

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

11 A. I don't think so.

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

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

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

21 A. As being more common than not, yes.

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

1 time?

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

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

10 MR. FRASURE: In August?

11 MR. MISHKIND: Correct.

12 A. If red cell casts were seen, yes.

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

16 A. I don't think so.

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

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

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

25 A. I think probably a BUN and

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

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

8 A. Yes.

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

12 MR. FRASURE: Objection.

13 But go ahead.

14 A. I probably would have asked her
15 about whether she had felt that her depression
16 was present or recurring and would have
17 recommended a trial of antidepressants on the
18 13th because a patient with depression and
19 recurrent somatic symptoms of unclear cause
20 will often have these related to the depression
21 itself and may be significantly improved with
22 treatment of antidepressants. On the 27th I
23 don't think I would have done anything
24 differently. I don't think that I necessarily
25 would have sent the patient to a neurologist,

1 but I think it would have been reasonable to
2 do.

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

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

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

11 A. Yes.

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

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

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

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

25 Q. In this situation none of this

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

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

21 Q. In what respect?

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

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

5 Q. By, by Vickie?

6 A. Yes.

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

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

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

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

25 MR. FRASURE: A later call?

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

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

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

14 A. Yes.

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

20 A. No.

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

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

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

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

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

23 Q. Yes.

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

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

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

12 A. Right.

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

19 A. That's fine.

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

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

22 MR. FRASURE: Objection.

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

1 my impression, but.

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

3 A. Right.

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

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

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

25 A. My feeling was that the obligation

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

5 Q. Okay.

6 A. And I think he did that.

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

10 A. By telephone?

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

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

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

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

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

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

1 it, but she didn't schedule an appointment.

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

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

7 MR. FRASURE: Objection.

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

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

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

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

25 Q. What about in October?

1 A. I don't think in October.

2 Q. What about in November?

3 A. I don't think so.

4 Q. What about December?

5 MR. FRASURE: If done in December
6 now?

7 MR. MISHKIND: Right.

8 A. I don't think so.

9 Q. All right. I asked you before, are
10 there any other aspects of Dr. Cola's care in
11 terms of how he handled things that you would
12 have handled differently?

13 A. I don't think there are any
14 substantive issues, no, with respect to those
15 visits that we're talking about.

16 Q. Do you feel that Dr. Cola complied
17 with everything that you have seen? That
18 Dr. Cola complied with the standard of care
19 throughout?

20 A. Yes.

21 Q. You have no criticism of his care
22 in any respect?

23 A. No.

24 Q. You have no criticism of his office
25 policy in any respect?

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

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

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

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

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

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

14 Q. They have not been provided to you?

15 A. No.

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

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

25 Q. But the issue is not did he cause

1 it, the issue is was it there to be diagnosed.

2 I understand you are saying it was not there to
3 be diagnosed.

4 A. Right.

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

15 A. Not during those months, no.

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

22 A. I think in January.

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

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

1 fault him or credit him.

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

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

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

20 A. Have you found that out yet?

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

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

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

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

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

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

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

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

24 MR. FRASURE: Object. Those are
25 too vague.

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

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

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

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

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

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

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

20 A. On renal function tests, yes.

21 Q. Okay.

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

25 Q. Doctor, that's not my question.

1 Just answer my question.

2 A. All right. All right.

3 Q. She has 50 percent -- she has lost
4 50 percent of her kidney function, that doesn't
5 mean that she's not able to get around.

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

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

12 A. Everyone does.

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

15 A. Correct.

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

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

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

1 A. At any given point in time, yes.

2 Q. Okay.

3 A. Prior to the onset of end stage
4 renal disease.

5 Q. Was she in end stage renal failure?

6 MR. FRASURE: When?

7 Q. Had she been in end stage renal
8 failure at the time?

9 A. No.

10 Q. What's your definition of end stage
11 renal failure?

12 A. It's irreversible permanent damage
13 to the kidney that leads to uremia and requires
14 dialysis or transplantation for restoration of
15 adequate clearance of uremic toxins.

16 Q. She required dialysis, correct?

17 A. For a time.

18 Q. Why?

19 A. Because she had acute renal failure
20 related to the rapidly progressive
21 glomerulonephritis.

22 Q. What's her life expectancy?

23 A. I don't know. It's diminished from
24 normal primarily because of the Wegener's.

25 Q. How is her life expectancy impacted

1 by virtue of reduced kidney function?

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

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

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

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

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

1 Q. Okay. More likely than not she will
2 have a flare-up in her Wegener's granulomatosis
3 at some time in the future, true?

4 A. Yes.

5 Q. And more likely than not when she
6 has a flare-up in her Wegener's granulomatosis
7 it will impact her kidney function, true?

8 A. Yes.

9 Q. And more likely than not when she
10 does have a flare-up in her Wegener's that
11 effects her kidney function she's at increased
12 risk of going into renal failure, true?

13 A. Yes.

14 Q. And she's at increased risk of
15 developing other complications including
16 hypertension related problems secondary to
17 increased renal disease?

18 A. Right. That's as opposed to
19 someone who has no renal involvement.

20 Q. Correct.

21 A. Or renal disease, yes, or doesn't
22 have Wegener's.

23 Q. Okay. Are you able to give me an
24 opinion to a probability as to what the
25 likelihood is that she will need dialysis

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

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

6 Q. Just periodic dialysis.

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

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

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

18 Q. More likely than not?

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

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

23 A. Right.

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

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

3 A. Okay.

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

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

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

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

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

11 A. Yes.

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

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

17 Q. Correct?

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

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

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

25 Q. Again, you are giving Dr. Cola the

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

8 MR. FRASURE: Objection. Very
9 repetitive.

10 Go ahead.

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

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

19 MR. FRASURE: Objection.

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

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

3 Q. Okay. And that becomes a factual
4 issue?

5 A. Sure.

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

8 A. Okay.

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

11 (Signature not waived.)

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

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1 CERTIFICATE

2 The State of Ohio,)

3 SS:

4 County of Cuyahoga.)

5

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

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

23

24

25

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

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

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

My commission expires March 20, 2002.

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