HOWARD C. PITLUK, M.D., F.A.C.S.

General and Vascular Surgery

6801 MAYFIELD ROAD, SUITE 340 • MAYFIELD HEIGHTS, OHIO 44124
(216)461-1800

Map 2, 1.990

Anna L. Moore, Esq.
Jacobson, Maynard, Tuschman & Kalur
1301 East Ninth street, Suite 1400
Cleveland, Oh 44114-1524

Dear Ms. Moore:

I am writing in regards to the case of William Brunn vs. George Saad, M.D., et al. 1 have reviewed the Deaconess Hospital admissions from 5-11, 6-15, 7-14, and 8-10-87. In addition, I have also reviewed Doctor Sryvalin and Doctor Saad's Office Records and the report of Plantiff's expert, Doctor John Bergan in the above mentioned case. I would like now to set forth my opinion regarding this case as it pertains to Doctors Sryvalin and Saad.

Briefly, on 5-8-87 Doctor Sryvalin saw Mr. Brunn in his office with severe claudication symptoms involving his left leg. Pulse volume recording results were available from the Vascular Laboratory at Parma Community Hospital and revealed a doppler ankle/arm index of .5 on the left and 1 on the right. Moreover, the wave forms in the ankle and foot region were markedly artentunted, The patient was subsequently admitted to Deaconess Hospital on 5-11-87. The History and Physical from that admission describes "severe ischemia of the left leg with disabling claudication". Arteriograms done on 5-11-87 showed a mid-thigh superficial femoral artery occlusion on the left with good collateral flow to reconstitute the superficial femoral and popliteal arteries above the knee. The patient had his options explained and on 5-13-87 had an above the knee left femoral popliteal artery Gortex bypass graft. Post-operatively the patient had no complications and within five days was discharged from the hospital with palpable dorsalis pedis and posterior tibial. pulses according to Doctor Srgvalin's note.

On 6-14-87, Mr. Brunn developed acute onset of severe pain in the left leg and was seen by Doctor George Saad, who was covering for Doctor Sryvalin. Doctor Saad did a non-invasive study which confirmed a graft thrombosis and on 6-15-87 took the patient to the Operating Room where he explored the distal graft, did operative arteriography and performed a neofemoral below the knee popliteal artery bypass graft using a 6 mm Gortex graft. On 6-18 the patient was started on Coumadin and on 6-30 was discharged with adequate anticoagulation to be followed as an outpatient. The patient apparently did well until *7-14-87* when he developed acute onset of swelling of the left calf and was seen by Doctor Saad. A diagnosis of deep venous thrombosis involving the left leg was made and the patient was admitted to the hospital, At that point he was noted to have prevalent drainage from one incision and a gangrenous ulcer of the left lower leg laterally. Mr. Brunn was treated by Doctor Saad with Heparin and Coumadin for a presumed deep venous thrombosis but on 7-28 the family requested that Doctor Sryvalin rake over the care of Mr. Brunn. Therefore, the patient was transferred to Doctor Sryvalin's service and three days later, on 8-1-87, was discharged from the hospital by Doctor Sryvalin. On 8-10-87 the patient

was admitted again to Deaconess Hospital with severe swelling and gangrene of the lower leg and on 8-14 underwent an above the knee amputation.

On August 22, 1988 Doctor John Bergan wrote a brief letter criticizing tho care given to Mr. Brunn in several areas,

He stated that there were marginal indications for the initial surgery as well as no documented reason why a prosthetic graft: rather than a vein by-pass was done. Moreover, he felt that the patient's venous thrombosis was caused by an underlying clotting abnormality which also was responsible for the two previous graft failures. He criticizes the patient's medication treatment for his deep venous thrombosis as well.

In reviewing this case several issues are quite clear. First, the patient was a reasonably young individual at the age of 60 with severe vascular disease. The fact that he was unable to perform the activities he wished to do because of his incapacitating claudication is a reasonable, accepted standard for performance of bypass in the Cleveland community. The use of Gortox in the above the knee position has been well documented as an acceptable alternative to veins in almost every instance. Therefore, Doctor Sryvalin's initial operation which was performed with great technical. ex-pediency and a good result post-operatively cannot be criticized. When Doctor Saad took the patient back to the Operating Room one month after the initial surgery for a thrombosed graft, certainly it would have been preferrable to use autogenous saphenous vein if this were available. How-ever, if saphenous vein is not available on the ipsilateral leg, the use of Gortex in the below the knee position is within the standards of care of the Cleveland community and is not at fault.

Up to this point I have no criticisms nor do 1 have any difficulty with the care given to Mr. Brunn. However, on his third admission to Deaconess on 7-14-87, I do not feel that the patient was properly or correctly diag-nosed. It is my opinion, since there are no venous studies either invasive or non-invasive to document a deep venous thrombosis, that Mr. Brunn in fact did not have venous thrombosis, but again, an arterial prosthetic graft occlusion. The swelling seen in the leg with gangrenous ulcers would lead me to this conclusion since post-operative revascularization edema of the lower extremity is the norm after surgery such as Mr. Brunn's. The fact that he had two femoral popliteal bypass grafts within a one month period of time further leads me eo this conclusion, Therefore, Doctor Bergan's criticism of the treatment of deep venous thrombosis is totally irrelevant to this patient since his problem was not one of venous disease but continued arterial occlusion. Unfortunately, this was not recognized and no further bypass graft was attempted. However, it should be pointed out that the rreatment with Heparin for venous disease would have been appropriate for this patient's arterial problem as well, and so serendipitously Doctor Saad and Doctor Sryvalin both administered appropriate care which is within the standards of our community in the treatment of graft thrombosis.

The chances of success of a third bypass to a lower extremity with very poor vascular runoff as documented by subsequent arteriograms during the course of the patient's second hospitalization would certainly have been less than 50 per cent.

In conclusion, although it is always unfortunate when a bad result occurs, I feel that both Doctor Sryvalfn and Saad exercisad appropriate medical judgement in their performance of the bypasses an Mr. Brunn. The ultimate amputation was probably unavoidable due to the extensive nature of his disease and all the previous attempts at bypass.

Should you have any further questions in this matter, please feel free to contact me at the above address.

Sincerely yours,

Howard C Pitluk M.D.

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