IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

LINDA PAINO,

Plaintiff,

vs.

RAGHU SAWKAR, M.D., et al.,

Defendants.

No. 3009009

Doc. 359

DEPOSITION OF HOWARD CHARLES PITLUK, M.D.

July 14, 1997

Tucson, Arizona

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PURSUANT TO NOTICE, the deposition of HOWARD CHARLES PITLUK, M.D. was taken in the offices of Charles Pitluk, M.D., 1925 West Orange Grove, Suite 101, in the City of Tucson, County of Pima, State of Arizona, before Carol A. Post, a Notary Public in and for the County of Pima, State of Arizona, on July 14, 1997, commencing at the hour of 1:30 p.m., on behalf of the Defendants, in a certain cause now pending in the Court of Common Pleas, in and for the State of Ohio, County of Cuyahoga.

* * *

I N D E X

E X H I B I T S :

Number	Description	Identified

(None marked for identification.)

HOWARD CHARLES PITLUK, M.D.,

having first been duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION

BY MR. HAWAL:

Q Doctor, please state your full name for the record.

A Howard Charles Pitluk, M.D.

Q And your current business address?

A 1925 West Orange Grove, Suite 101, Tucson, Arizona.

Q How long have you been practicing here in Arizona?

A Just short of two years.

Q You had prepared a report January 23rd, 1997, which, among other things, itemized a number of written materials that you reviewed in preparation for your involvement in this case as an expert?

A Correct.

Q Correct?

Are there any additional things that you've reviewed since that time, since the items that you itemized in your report?

A Just Dr. Seaberg's (phonetic) deposition.

Q Okay.

MR. BONEZZI: And the films.

THE WITNESS: Oh, yes. And I also saw the actual x-rays.

BY MR. HAWAL:

Q Which x-rays?

A The Fairview x-rays of Ms. Paino's balloon angioplasty and her operative arteriograms that were performed by Dr. Raghu Sawkar and the preoperative films, as well, the aorta or femoral arteriograms.

Q Do you know Dr. Sawkar?

A Personally, I've met him in my capacity as president of the Cleveland Vascular Society several years ago. I have met him at some meetings, but I don't really know him personally.

Q Does your report set forth or summarize the opinions that you expect to express in this case?

A I believe so.

Q You mentioned in your report -- and I'm going to go through your report somewhat with you, if we can -- you indicate that Dr. Sawkar treated Mrs. Paino at this time for both a left and right superficial thrombophlebitis of her saphenous system,

and you're referring to 1993.

A Correct.

Q Where are you obtaining that information that he treated both her left and her right thrombophlebitis?

A From Dr. Sawkar's office notes.

Q Where do his office notes refer to the right-sided saphenous pain treatment?

A May I look?

Q Sure.

A I have these records here. May 27, 1993, the note says --

And I'm quoting from reading his handwriting.

Q Uh-huh.

A -- left leg severe, V-vein, which is varicose veins, with superficial phlebitis, right mild.

So that to me indicates that he was treating both the right and left legs for superficial phlebitis.

Q What was the nature of the treatment that he provided for the right-sided thrombophlebitis?

A Well, I believe the treatment is systemic.

Eventually she was put on Coumadin.

That's not for a side, an individual side. That treats everything. It will treat both right and left.

Q She had severe thrombophlebitis on the left? Is that your interpretation?

A Severe varicose veins --

Q Okay.

A -- with superficial phlebitis, is the way I'm reading that on there.

Q Okay. And right mild?

A Right.

Q Did you ever find any other notation or reference to a right-sided phlebitis?

A I don't believe so, no.

Q You describe her as being seen by Dr. Sawkar in 1995 for severe claudication involving her left leg.

What were the symptoms as you understand them to be in 1995 that lead you to conclude that she had severe claudication?

A Well, she cla ms that first of all she went to see Dr. Sawkar for the leg pain.

So to me that indicates that she has significant severe whatever word you want to use, disease.

She couldn't walk, apparently, without

pain. And then according to Dr. Sawkar's notes, after seeing her initially, when he saw her again she was complaining of having rest pain even on that left side, and that to me indicates severe disease.

Q Were there any physical findings on physical examination described by Dr. Sawkar that would further give any additional information about the extent of her symptomatology or her clinical condition with regard to her peripheral vascular disease on the left?

A I believe the pulsus were markedly decreased or they were -- I don't even remember if they were even palpable at all.

Q And you would be getting that from his records?

A Yes.

Q When you talk about rest pain are you talking about limb-threatening ischemia?

A Usually rest pain is limb threatening, correct.

Q So would you characterize a patient her age, if she is exhibiting rest pain, that she is in need of emergent treatment of her: peripheral vascular disease?

A No, not emergent.

Q Would you consider her in need of invasive interventional treatment?

A I do, yes.

Q Doctor, generally, in the area of peripheral vascular surgery and peripheral vascular disease, is a physician permitted to rely solely upon a history and physical examination in making a determination as to whether or not a patient needs interventional treatment in the way of angioplasty or surgery?

A I don't think you could be faulted for that.

Although, I do feel that there are other studies that should be done before you do interventional; and specifically, those are noninvasive peripheral vascular laboratory studies.

Q All right. Can we agree that if a physician suspects that a patient is being disabled from a significant peripheral vascular disease that that patient, prior to being put through an invasive procedure like an angioplasty or a bypass surgery, that that patient should have noninvasive studies, vascular studies performed?

A For the most part.

Although, if the ischemia is acute

enough or severe enough, no, you do not need to do that; you can go right to the arteriogram.

Q If ischemia is severe enough, you're talking about ischemia that will be producing cyanosis and perhaps ulcerations?

A Could. Those are two things that could occur; correct. There's others, but yes.

Q What are the other indications of severe enough ischemia that would warrant a physician doing an invasive procedure without doing vascular peripheral studies?

A Well, very easily, patients come in with severe ischemic rest pain; they can't sleep at night. You examine the leg. The foot is either very red or very pale, one or the two, and the redness is the skin trying to dilate up. But it's an indication of poor circulation; it's severe ischemia.

As I said, the physical pain may be so severe that the patient needs to be arteriogrammed and there's really no point in doing noninvasive studies.

If you know clinically by examination that the foot is ischemic enough that it's going to require intervention, very often I won't even do a noninvasive study because I know what it's going to show; it's going to show an index of .2 or .3, and that

really is of no help. It doesn't help the patient. It just delays their treatment.

Q In terms of a patient that comes in complaining of that degree of severe ischemia, what kind of --

I mean, you talked about seeing discoloration, redness, or blanching of the foot.

Is that one of those --

A Toes, foot, yeah, mostly toes.

Q -- of the findings that you'll see?

Were there any findings that you saw that Dr. Sawkar articulated in his records that would indicate that he observed ischemia to that extent with this patient?

A I don't recall. I don't think --

I know he talked about the noninvasive studies when she dropped down to a .24 index, which is ischemia. He talks about her having night pain; those were his words, night pain.

So that, to me, that's -- I'm seeing something, but that's historical.

And that in conjunction with his physical examination would indicate that the patient, I think, should have noninvasive -- further invasive intervention.

But he also did have a noninvasive study.

Q Do many elderly patients with peripheral vascular disease have concomitant medical conditions, either orthopedic or neurologic, that would create some difficulty diagnostically in determining whether or not a patient's complaints of pain are ischemic pain or of another source of origin?

A Not many.

But that can occur if you have two disease processes occurring.

In an elderly individual who has palpable pulsus, as an example, and has terrible pain in their legs when they walk, that patient has clear neurologic disease and not vascular.

If, on the other hand, the patient has a history of having back problems and comes in with no palpable pulsus and pain when they walk in their legs, then you need to do more studies to sort out what's the etiology of her pain; is it vascular, is it orthopedic or neurogenic, or is it both?

Q Do not the vascular texts that you're familiar with not indicate that noninvasive vascular studies are important in order to differentiate between a patient's ischemic pain, if it exists, and

nonischemic pain that could be of an orthopedic nature?

MR. BONEZZI: Objection.

Go ahead and answer it.

THE WITNESS: I don't really discuss these things with our vascular techs, to be honest with you.

BY MR. HAWAL:

Q Pardon me?

A I don't discuss these things with our vascular technicians.

Q Texts, texts.

A Oh, I'm sorry. Texts.

As I said, only in situations where you have possible confusion.

As I said, if you have a patient who has palpable pulsus, I simply write -- I don't bother with noninvasive studies; I just send them right to the person who takes care of backs, whether it be the neurosurgeon or the orthopedic surgeon.

Q Did Linda Paino have any concomitant illness that would affect the symptomatology in her left leg?

A Possibly her cardiac disease could, if she has poor cardiac output and therefore poor circulation.

Q Anything else to your knowledge?

A I don't believe she was diabetic, but I'm not sure; I don't recall. If she were diabetic, she had early diabetes. That would affect it. Those are the two major things.

Q Do you know if she had any neurological or orthopedic problems in her left leg?

A No, I don't.

Q Doctor, you indicated earlier that Linda Paino was experiencing claudication and that progressed to the point of rest pain to the extant that she was disabled and was basically unable to walk very far. Is that a fair understanding?

A I can't say --

I'm sorry.

I don't know if she was disabled. I just know from Dr. Sawkar's notes that she was having pain when she first was seen, she was talked to a month or so later or a little bit more, and now she had night pain at rest.

She called Dr. Sawkar after his explanation to her about balloon angioplasty or other modalities and said that she actually wanted to do the angioplasty. She actually requested that, as far as I can glean from the records.

And so to me that indicates progression of the disease.

Q In terms of your understanding of this case is it consistent that based upon your understanding of the vascular studies and the degree of pathology that you can determine from the medical records that she was having disabling pain to the extent that she was barely able to walk from Dr. Sawkar's parking lot into his office?

A Yes, absolutely, just looking at the arteriograms and getting the history and et cetera, yes.

Q Was the right leg symptomatic at all?

A Not as much as the left, apparently.

Q Well, can you tell us anything about the degree of symptomatology in her right leg?

A I don't believe she had a lot of symptomatology in the right leg, as far as I can tell. I --

My focus was the left leg.

Q Did you see any description of any complaints about the right leg?

A I don't know. I don't think I did.

Q What are the usual noninvasive studies that a vascular surgeon will perform on a patient with

peripheral vascular disease before recommending an invasive procedure like a balloon angioplasty?

A Or an arteriogram.

Q Do you mean an arteriogram or a balloon angiogram?

A Balloon angiogram.

Well, they will first do a physical examination and a history and get the history as to what kind of symptoms the patient is having.

Physical examination will entail examining the extremity involved and examining, actually, the entire vascular tree to get an idea as to the carotid arteries and the peripheral circulation up in the upper extremities and et cetera, and then of course focusing on the limb in question with pulse examinations, skin examinations, making sure there's no ulcerations interdigitus, or between the digits, ulcerations that can be missed, things of that nature,

Then if the pulse examination and the physical examination and the history warrant, I would do a noninvasive peripheral vascular examination in the laboratory, a pulse volume recording that will give you -- with Doppler studies that will give you some hard data to corroborate your physical examination,

If that shows significant enough

disease, I will usually use some conservative measures, if possible; and then if those fail or if the patient's still having severe symptoms, go to an arteriogram, just an angiogram; and if at that point in time the angiogram warrants and there are lesions that are amenable to, we will perform a balloon angioplasty.

Q In terms of the nature of the elicited history and the quality of the physical examination that you observed from reviewing Dr. Sawkaz's office chart, do you find that that was detailed and thorough to the extent that you like to see with examinations that you perform with your own vascular patients?

MR. BONEZZI: Objection.

Go ahead and answer.

THE WITNESS: I believe it was thorough, yes.

BY MR. HAWAL:

Q You talked about angiography. Is it generally recognized in your profession that angiography, while it will identify lesions, it will not generally identify the degree to which those lesions are capable of producing disability of a vascular origin?

A I'm not sure I understand what you mean.

Q Well, what I'm trying to say, isn't it

true that some lesions on an angiogram will look like they are capable of producing significant disability and in fact later noninvasive studies show that those lesions are not significant in terms of producing symptomatology, and the opposite is also true, that some lesions that don't look bad on film in fact can be causing severe ischemia? Is that generally understood to be the case?

A Generally that's -- Those are the exceptions and not the rule as you seem to be making out. It is very rare that --

First of all, you do the noninvasive studies first before you do the angiograms. You sort of implied the other way around. In other words --

And that's important, because you wouldn't be doing the angiograms unless the noninvasive studies corroborated the fact that you had something that needed to be looked at with an invasive angiogram.

Once you do that angiogram, you may find a lesion that you -- doesn't look terribly bad, but yet is bad according to the noninvasive studies. And that's primarily because angiograms are two-dimensional films and you're dealing with a three-dimensional vessel.

And so on the two dimensions that you're

looking at, the flat film, if you will, you're seeing length and width; you're not seeing depth. If you sort of rotate that patient, that lesion that looks like it might be only 20 percent narrowed might in fact be 90 percent narrowed.

Does that answer your question?

Q Sure.

And in terms of diagnostic significance, in terms of leading a patient up to a balloon angioplasty or a bypass procedure, I take it, then, that while an arteriogram is an important component, the primary determinant as to whether the patient is amenable to surgery or surgery is appropriate is the noninvasive flow studies?

A No, no. No, that's not true.

The primary -- There -- there is -- There isn't one just primary. I think the history has to be taken into account, the noninvasive studies, and the arteriogram.

If you ask anybody what the gold standard is, the gold standard is the arteriogram. That's the study which you will use in conjunction with a history and in conjunction with the noninvasive studies to tell you if a lesion is critical or should be addressed.

Q Is it not true that the arteriogram will not indicate the degree of stenosis or occlusion because it is only two-dimensional film?

A No.

I'm just saying in some lesions, and those are the exceptions and not the rules, you can be fooled. But most of the time, 90-plus percent of the time or more, the arteriogram gives you the answer.

Q Are you familiar with medical literature both in terms of the peer-review journals that I'm sure you have seen in your practice of vascular surgery, like the Journal of Vascular Surgery that's sitting on your desk, as well as vascular texts, that indeed the gold standard or the determinant as to whether a patient is going to have an angioplasty procedure or any invasive procedure for peripheral vascular disease will be flow studies rather than anything else?

A No. I don't agree with that.

I believe that the natural gold study is the arteriogram. And that, I think, has been documented in the journals.

Q What does the ankle brachial index tell you about the degree of peripheral vascular occlusion in a patient suspected of having claudication or rest pain?

A The ankle brachial index is an attempt to quantify the degree of narrowing and disability that can be caused by this narrowing. So anything above .9 is essentially normal, normal flow.

When you get down to the level above .75 you begin having claudication symptoms. The lower you go, the more significant, most likely, is the occlusive disease.

At a level of around .4 you can heal below the amputation. At a level of around .2 -- say .25, you begin having ischemic rest pain. At a level of around .1 you have actual ulcerations.

So it gives you a ballpark idea as to the kind of disease you're dealing with and perhaps a glimpse as to what to expect in the future.

Q A finding of .7 on a patient's index is not consistent at all with rest pain, is it?

A Usually not, no.

Q .7 is not an indication for an invasive procedure, is it?

A Well, it depends. It depends on how much claudication the patient's having.

Q Do you promote invasive procedures for claudication?

A Yes, depending on the individual.

Q Is that something that you usually recommend for a patient with claudication?

A Depends on the individual.

Q And what is the determining factor is if a patient is having claudication as to whether or not you're going to recommend an invasive procedure like an angioplasty or a bypass?

A The degree or that the lifestyle is being altered by this claudication.

Q I take it that the younger the person, the more active, the more likelihood that you're going to be giving them an option of an invasive procedure.

A Age has nothing to do with it. 1 live in Arizona where I'd say most people are old. But interestingly enough, age is no longer a determining factor as to who gets operated upon or who gets an invasive procedure and who doesn't.

Q If a patient is having a claudication to the extent that they're able to spend an hour and a half to two hours on their feet without any real significant complaints and they're 75 years old, would you expect that that's a patient that you would be promoting an invasive procedure for at age 75?

A Perhaps you and I don't have the same understanding of claudication.

Q Okay.
A Standing on your feet has nothing to do with claudication.
Q Walking.
A Walking is a different story.
Q That's what I meant by --
Active on their feet.
A It depends on --
Okay. I'm sorry. I --
Q I'm sorry I wasn't clear, but go ahead.
A I've got patients who are 75 years old who come in and say: Doc, you know, I just -- I love to garden, that's all I care about. You know, when I walk to the store I get pain in my legs, I have to stop a couple times, but I don't care; you know, I'm doing just what I want to do.
And I say: God bless you, keep in touch, I'll see you.
I'll get noninvasive studies, perhaps, I usually will, maybe put them on some Trental, have them be on an exercise program, and I won't do anything more.
I have 75-year-old people come in to me and say: Doc, I love to golf, I live to golf. If I can't golf, I want you to shoot me right here on this

spot.

And to that person I say: Well, we have some options and these are the options. And I explain to them about noninvasive studies.

And after I do those and he keeps telling me he has pain and he can't walk through the pain, and I say: Let's do an arteriogram and see what we can do to help you.

And those are two scenarios that happen all the time. And that's what I mean by lifestyle.

Q We do know that this patient had a .7 --

A -- resting.

Q -- resting index; correct --

A Yes, correct.

Q -- on the left side?

A Yes, correct.

There's some question, apparently, if it's on the left or the right.

Q A question in whose minds?

A Well, according to the deposition of Dr. Sawkar.

Q Do you find that a little bit suspicious?

A No.

MR. BONEZZI: For what?

THE WITNESS: Suspicious for what?

BY MR. HAWAL:

Q Suspicious for it being manufactured after the fact, that it be something --

A No, that it's --

Q -- be something that he's trying to pass off as being a mistake that he made.

A Well, I think he's saying that there was a mistake made insofar as the noninvasive studies are concerned, if that's what you mean, which he signed. But do I --

Am I suspicious? No.

I think if you then take the next statement and the next finding, which is after exercise it dropped down to .24, the index, that is, that's very, very consistent with severe stenotic disease.

Q It's not consistent with rest pain?

A .24 would be.

And don't forget, the noninvasive studies were done a couple of months or more before the angioplasty was performed.

Q Doctor, are you saying that when it dropped on exercise to .24 that that is consistent with rest pain?

A No.

With severe disease.

Q What was the condition of her right side?

A Meaning?

Q Her right leg in terms of the --

A What do you mean the condition?

Q -- the index, the ankle brachial --

A I think it was like .4 or something.

Q And it dropped --

A I don't recall what it dropped to.

Q And would that indicate a much more significant degree of disease or lesions on the right side; correct?

A It indicated, according to the arteriogram, that she had a total occlusion on the right side. So --

Q She was not having limb-threatening ischemia on the left side, based upon the --

A Left side or the right side?

Q On the left side.

-- flow study?

A Well, I think when you drop down to a .24 on exercise it's limb threatening, yes.

Q Do you think Dr. Sawkar with a resting index of .7 would have been -- it would have been wise

of him to look at other possible causes of her complaints of rest pain or pain at night in her left leg?

A No, I --

In this patient?

Q In this patient.

A No. I think he had plenty of information regarding her extremities with the exercise studies and his physical examination to -- to warrant what he did.

Q Is it true that about 80 percent of patients with intermittent claudication improve or remain stable without surgical intervention?

A I -- I don't know. I don't think that's a fair statement, but --

Q Is it fair that a majority of claudicaters, intermittent claudicaters, remain stable or improve without surgery?

A At what level of claudication?

Q Intermittent claudication.

A At what level; half-block, six blocks? See, claudication is a very big term.

I'd say of the people who have half-block claudication, 100 percent of those -- I should say 90 percent of those, not only do they not

get better; they get worse. But people who have four-block claudication appropriately treated, I would say a majority of those, probably over 50 percent, probably won't need more than the conservative treatment they're getting. And it depends, again, on the individual.

Q In your experience, what type of physicians generally perform balloon angioplasties of the lower extremities?

A In my experience there are three types; the invasive radiologist, the vascular surgeon, and the cardiologists now are getting in on the picture.

Q And who is the most likely physician that you're going to see in a suite performing balloon angioplasty? Is it going to be an invasive radiologist?

A In my hospital, yes.

Q In most hospitals that you've been associated with?

A That I've been associated with?

Q Yes.

A Yes, that's true.

Q Do you perform them?

A No. I probably should, but up until now I haven't.

Q Do you consider yourself an expert in peripheral vascular disease as it relates to balloon angioplasty procedures?

A Oh, yeah, absolutely.

Q What qualifies you as an expert if you've never done one?

A I've been involved --

You know, when you do a balloon angioplasty and you send it to a radiologist, you need to be -- you're the man who's in the box, not the radiologist; because if there's a problem, it's you, the surgeon, who has to fix it.

So as a result, I know all about them; I know how they're performed, I know complications of them, I know what to expect, what to look for, et cetera.

And if anything does go wrong, it's me who has to fix it, not the radiologist.

Q Is arterial rupture rare if an appropriately sized catheter is used?

A Define rare.

Q Less than .1 percent incidence rate.

A I think that's low. I think that it happens more often than that.

Q Less than one percent?

A I think it happens probably more in the neighborhood of two to five percent.

Q Can you point me to any literature that would support your contention that it happens two to five percent of the time?

A Not offhand.

Q There is literature out there that quantifies the incidence rate of some complications such as that generally?

A There is literature that speaks to that, yeah.

Q What is the usual cause of rupture, arterial rupture, during an angioplasty?

A The balloon expands and ruptures the artery. It's usually because the atherosclerotic disease is so severe that the artery just cracks or breaks.

Q Is it your opinion in this case that there was a rupture, arterial rupture?

A Yes.

Q And that is evident from the radiology films that you've reviewed?

A You -- We could see that on the films. It's also evident from the clinical picture as to what developed.

Q And when you have a patient who has an arterial rupture, is it appropriate to take that patient out of the OR without dealing with that rupture?

A It depends, again, clinically on how the patient's doing and what's going on.

You know, you can have a very, very small rupture, a very small leak, if you will, and I believe often do. And I have certainly seen it more than -- on more than many occasions, actually, where there is a small leak of the small mount of extravasation of contrast where you crack the plaque --

And understand in a balloon angioplasty you're literally rupturing the lining of the artery; that's the whole intent of this.

The key is to keep the rupture contained to the artery wall and not outside the artery wall.

But occasionally you do get extravasation. That in and of itself is not an indication for doing anything more than watching the patient, if the patient is stable, if you have good pulsations, if there's no evidence of any further bleeding.

Q You have seen the radiology report that indicates that there was a large amount of contrast

material outside the venous system?

A I have it right here.

That was done a day later, dictated a day later.

Q But it was reviewing the same film.

A Of a day later, that's correct.

Q Do you agree that there was a large amount of contrast?

A There was contrast outside. I don't know how to quantify a large amount.

Q Wouldn't it be inconsistent to have an arterial rupture to the extent there was that amount of contrast outside of the venous system that -- or the arterial system that would be capable of producing normal peripheral pulsus?

A With just --

No, because the patient did have palpable popliteal pulsus after the procedure, which would indicate that there wasn't that much contrast outside the wall.

Don't forget, this is a radiologist who's making a very subjective assessment of what he sees on one x-ray.

Q Can you explain why Dr. Sawkar didn't see what the radiologist saw and what you see?

A I don't think Dr. Sawkar actually had a cut film at the time; he had probably real-time fluoroscopy, when you do that.

Q Can you explain why he still doesn't see it?

A The images aren't anywhere that clear. I mean, you might see a little bit of extravasation; maybe not, but you shouldn't -- you won't see the frozen-in-time, if you will, shot that they get on the x-ray.

Furthermore, the x-ray is a lot bigger than the screen is that Dr. Sawkar's looking at. And so it's magnified.

Q Did Linda Paino have three levels of disease in her left leg?

A I think that's probably more than three levels of disease; yeah, a lot of disease, diffuse.

Q What kind of patency would you expect for her after 24 months or -- after 12 months with angioplasty, after angioplasty?

A It's -- it's hard to say. Some people are stinting these things now. Some people -- some people aren't doing them at all. Some people -- It depends on an individual.

But I think a patency at 12 months, you

would hope to see in the neighborhood of 65 to 70 percent.

Q And a patient with her vascular disease, you would?

A Oh, yes, yeah.

Q So you would consider her to be a good angioplasty candidate?

A I think at the time she was a pretty good candidate, yeah.

Q You indicate in your report that it was Dr. Sawkar's feeling at the time that the right vein would have been equally diseased, given her history, thus precluding its use; correct?

A You quoted me.

Q That was my intent.

Why did he try to harvest the left saphenous vein if he knew that that was the vein that he had had -- or she had had significant problems with back in 1993 with regard to phlebitis and DBT's?

A Because he was on the left side and he -- and the incisions were there, and that's the appropriate thing to do.

And whether or not you have phlebitis doesn't necessarily mean that you're going to have a nonusable vein.

Q Would it be the expectation, based upon your knowledge of this patient's history, that the likelihood of that vein being usable would be very remote?

A I -- I wouldn't say that, no.

Q What would you say; that there was a good likelihood that that vein would be usable?

A I'd say that you'd need to look at the vein and see if it was usable.

Q And knowing the extent of disease on her left side versus what is in the record about her right side --

A Are we talking about the veins now?

Q Yes, saphenous veins for harvest.

A Okay.

Q -- should Dr. Sawkar have not gone to the right leg and harvested that vein as Dr. Droubi did later?

A I don't believe so.

Q Why not?

A Well, for several reasons, the first of course is which he felt that the vein would have -- After looking at the left side he felt that the right side would have been equally bad, number one.

Number two, I think that in his own mind

he felt that a prosthetic wrap would work fine. And I have no problem with it at all. I think that prosthetic wraps do work fine and give good patency and good limb salvage. So I saw no reason to -- Personally I think it was the correct thing to do.

Q Does not the literature indicate that four-year patency rates for synthetic cortex grafts are much lower than vein grafts?

A Define much lower, please.

Q Significantly lower, in terms of 30 or 40 percent lower.

A No.

Q 20 percent lower?

A Depends on the individual, depends on primary patency, secondary patency rates, depends upon anticoagulation; depends on a host of factors --

Q All things --

A -- with the point being that they do work.

Q All things being equal, Doctor, you always want to have a vein as opposed to a cortex graft, don't you?

A If you can get it from the ipsilateral side, yes; if not, no.

And to be honest with you, in the

above-the-knee, fem-pop position, as an example, I personally, in my experience -- and there's literature that will back that up, as well -- the cortex graft works just as well as a vein graft.

Q That's your experience?

A Oh, yeah.

Q Certainly, I don't --

Would you be able to point me to any literature that would support the position that the experience among vascular surgeons is similar to yours?

A Yeah, there are articles about above-the-knee fem-pop graft of the cortex being --

Q -- equal to or better than?

A -- equal to or about the same.

Q You don't have them --

A Not offhand, but they're in there.

Q What should be done in terms of monitoring a postop bypass patient to ensure graft patency postoperatively?

A Physical examination is the most important thing. Generally speaking, if the graft fails, you know it because the patient's leg becomes very ischemic.

You could do Doppler studies or if pulsus are palpable you palpate the pulsus and if you

lose the pulsus, then that's one sign.

You can do a Doppler bedside evaluation of the pulsus. And if they change and/or you lose those, that's another sign.

But the patients will usually tell you my grafts are occluded, because they develop severe pain.

Q Can we agree that by midnight this patient's graft went bad?

A I believe that's about the right time on the 27th -- 28th.

Q Right after the --

A -- bypass.

Q -- midnight -- after the bypass procedure?

A The bypass, yeah.

Q What was done for her?

A She was evaluated and monitored, basically.

Q And when a graft occludes, how much time is there, generally recognized, before the patient's ischemia progresses to the point that it is -- that the limb can be nonsalvageable if reoperation is not performed?

A That really depends upon the circulatory

status of the patient, the level of the graft, the collateral blood flow, et cetera.

Q Is it generally recognized in the literature that you want to do a redo by 12 hours after thrombosis or graft occlusions?

A If you're going to do a redo, yeah.

Q And in fact, if the neurological status of the affected extremity starts deteriorating, you want to do it sooner than that; correct?

A Again, if that's your intention, if you can get to it, yes.

Q And you know from Dr. Sawkar's testimony that it was his desire to attempt a redo?

A From his testimony?

Q Yeah.

A There was talk about him bringing in a cadaver vein. Is that what you're speaking to?

Q Yeah, uh-huh.

A Yes.

Q Was that an appropriate decision or a recommendation to the patient?

A Yeah, it's -- it's appropriate.

Q And when would you like to have seen, based upon your review of the nursing notes, as to when you would have liked to have seen that procedure

implemented or be done?

MR. ALLISON: I'm sorry. Could you repeat that question?

MR. HAWAL: Sure.

BY MR. HAWAL:

Q From your review o the nursing notes when would you have liked to have seen that procedure begun?

A Sometime within the 24-hour period that the graft occluded.

Q 24 hours?

A Yeah.

Q And why 24 nours and not 2?

A Because 1 don't think there's a magic number and I think once you make a decision to revascularize, you have, you know, a little bit of time to -- to make that decision and to go ahead and to do the revascularization, and especially in somebody who's been ischemic for a while, and I mean chronically ischemic, like she was.

Q All right. So it's your position that as long as that surgery was started within 24 hours, it would be appropriate?

A Sure.

I think it was appropriate to do it when

Dr. Droubi did it, too.

Q And would the likelihood of success have been greater if it had been done within several hours of the graft failure or occlusion?

A Would you define success, please?

Q Yes.

Limb viability in terms of functional use of the limb, lack of neurological -- permanent neurological damage.

A You know, it seems to me this woman did have a functioning, viable limb 36 hours later or 40 hours later.

Q But is it generally the case that the sooner you do it, the more chance of success you're going to have in terms of having a viable limb that's going to function relatively normally?

A You know, no, not really.

I think what you need to talk about --

When you're doing limb salvage, you're doing limb salvage.

The operation that was performed by Dr. Droubi wasn't done to salvage the peritoneal nerve; it was to salvage the foot; limb salvage, not nerve salvage.

And that's what you're shooting for in

all of these operations. That's the same thing Dr. Sawkar was shooting for, is the limb salvage.

And I think the other stuff you're talking about, foot-drop and peritoneal nerve palsy, you know, that happens very early on, within two, three hours, actually, and that usually -- Very often that will come back, because the peritoneal nerve is a peripheral nerve.

And, in fact, one of the consultants even commented about that.

Q Doctor, can we agree that the sooner one revascularizes an ischemic leg the better off the patient's prognosis is going to be?

A For limb salvage, yes.

Q For functional limb use?

A No.

Time matters in limb salvage, but the functional use, I've never seen that it would matter you do it in 6 hours, whether you do it in 24 hours, if the limb is -- if the limb survives.

Q Can you give me any references to any medical literature that supports that position that you've just stated?

A About functional use?

Q Yes.

A No.

But I can't give you any that disproves it, either.

I mean, we're talking about limb salvage here, and that's the key.

Q Would Mrs. Paino have suffered less of a degree of dysfunction if she had had Dr. Droubi come in and bypass that graft at 2:00 a.m. on the 27th -- or that would be the 28th now, of February?

A I don't think so.

I mean, and I use as my reference for that the fact that almost a month after Dr. Droubi's successful limb salvage bypass he was still debriding dead muscle. That was occurring a month later. That dead muscle occurred a month after the bypass.

I don't think we can sit here and say: Well, that happened on the 27th or the 28th at 2:00 a.m.

That dead muscle happened on the 26th of March.

So we have a functional graft; we have a foot that's now saved. But the muscle's still dying in the calf.

How do you explain that except the fact that it doesn't matter when it was done insofar as limb

salvage is concerned?

Q Would you expect that Dr. Sawkar would have fallen below the standards of care if he was giving the family only an option of amputation?

A Absolutely not.

Q So that would have been within the standard of care for him to do?

A Absolutely.

Q I take it you disagree with Dr. Seaberg in his testimony that earlier surgery, in terms of attempting to revascularize that leg, would have been the appropriate step to be taken?

A No, I don't disagree.

I think you might be misunderstanding me when I say that you can wait.

I think optimally, if your choice is to revascularize, you revascularize as quickly as you can.

But sometimes your choice is not to revascularize. Sometimes the better choice is to proceed with amputation.

Q Well, why did not Dr. Sawkar seek to revascularize sooner?

A Maybe he didn't feel it was an option.

Q I thought he testified that he wanted -- he was recommending to the family that that would be an

option.

A An option, but not a very good option.

I think -- First of all, I believe he said the family didn't want the cadaver vein. And I think that was the only thing he offered them.

He also, if you look at the record, I think, felt an amputation was -- and told the family many or several occasions that he feels the patient will come to amputation. He told the patient that.

Q Only as secondary procedure after revascularization failed?

A Yeah, after his fern-pop bypass failed and as she progressed.

Q Well, didn't he say that if the cadaver vein harvest procedure was unsuccessful, then she would probably at that point require an amputation?

A Oh, for sure.

Q Well, isn't that what he was attempting to express to the family?

A Well, I -- He did express that.

But the family refused, according to his testimony.

Q Uh-huh.

A And again, this is his testimony.

Q Yes. Did you believe his testimony in

that account?

A He did this under oath, didn't he?

Q I'm just asking you.

A Well, did he do it under oath?

Q Presumably.

A Weren't you there?

Q Presumably.

A You weren't there?

Q I was there.

A Well, then I -- of course 1 have to believe it.

Q Did you see any reference in the medical record about refusal by the family for any medical procedure or recommendation by Dr. Sawkar?

A No.

Q If you had a patient that refused your recommended treatment and you knew that the alternative would be an amputation, wouldn't that be something that you would want to chart in the record?

A I have it all the time when people want to go to amputation and I -- You know, I always put down that the patient will come to amputation.

Q Isn't it true --

A I think Dr. Sawkar actually has a signed amputation --

Q That's another question.
A Well, I mean, it's in the record.
Q My question, my question, Doctor --
A Okay.
Q -- is if you are recommending to one of your patients a medical procedure that you think may salvage a patient's extremity and that patient is refusing your medical advice and recommendation and that you know that the only alternative upon refusal is an amputation, and the family or the patient continues refusal, will you not document that refusal in the medical records?
A Based upon what I know about medical/legal reasons, yes, medical reasons.
Q In fact, you would have witnesses to that discussion, wouldn't you?
A No.
Q No?
A I mean, purposely?
No.
Q As long as it was documented?
A I usually try to document everything only because it's, you know, the smart thing to do in this climate. But it's not negligent not to.
Q What is your understanding as to when

Dr. Sawkar explained the complications of angioplasty to this patient?

A My understanding is he explained it on several occasions --

Q Before the proceeding?

A -- on at least --

Yeah, on at least two.

Q What is W.L. Gore (phonetic) & Associates you have referenced in your CV?

A What is it?

Q Yeah.

A It's a company that makes --

Q Makes cortex?

A Makes cortex, yeah.

In my CV, I was --

Q Pardon me?

A Oh, the suture, there was some carotid patch studying. I think there was a fem-pop study, also.

Q Is that a clinical trial you were involved with?

A Well, yeah. I think it was a movie that I made on the -- I was involved with the clinical trial of the suture and I did a couple of films using their products and procedures that I happen to do. And they

asked if they could film me.

Q Do you have certification of added qualifications in vascular surgery?

A No. I finished in 1979 before that was available.

Q Did you do a fellowship in vascular surgery?

A No. I spent nine months with John Bergan, B-e-r-g-a-n, and John Yao, Y-a-o, at Northwestern at the time when fellowships were being developed, based upon my personal clinical experience.

Q What is the degree or percentage of your practice that is devoted to peripheral vascular surgery as opposed to general surgery?

A It's about --

MR. ALLISON: I lost that whole question.

BY MR. HAWAL:

Q What is the percentage of the practice that is devoted to peripheral vascular surgery as opposed to general surgery?

A Approximately 50/50. It would have been more, perhaps, vascular lately.

Q Do you know Dr. John Porter?

A I don't know him personally. I've met

him and I know who he is.

Q What is his standing in the community of vascular surgeons?

A He's a professor of surgery at the University of Oregon, of vascular surgery.

Q What is his standing among your peers; well respected, well regarded?

A Let's just say he's controversial.

Q In what regard?

A He's pretty dogmatic, pretty pragmatic. I think Dr. Porter might even agree with that. And maybe not.

But he's very opinionated when it comes to certain things, a very big believer in reverse saphenous vein as the only conduit of choice for revascularizations.

I think he is looked upon as the advocate of saphenous vein, almost like a torchbearer it. So that's his regard.

I think people who don't particularly care for saphenous veins might look upon him as a little off base.

I think he's a very good man; I think he's a good surgeon.

Q Are you affiliated with this hospital

right next door?

A Northwest Hospital, yes.

Q Columbia Northwest Medical Center?

A That's the one.

Q I mean, is this where your practice is confined?

A Primarily. Primarily. Not confined, but --

Q What size hospital is it?

A It's about a 200-and-some bed, 220-bed hospital.

Q What caused you to leave Cleveland or what was your reason for leaving Cleveland?

A Primarily the weather. 1 just couldn't stand it anymore.

Q Are you still PIE insured?

A No, I'm not.

Q In terms of your familiarity with the attorneys at Jacobson, Maynard, how many of them do you know socially as opposed to jus, strictly on a professional basis?

A Did I know or now?

Q Both.

A Well, now I don't have any social relationships with them since I'm in Arizona.

One of them was a neighbor of mine many years ago, maybe --

Q Is that Pat?

A Pat Murphy, right.

And we would see he and his wife and his kids ccasionally socially, being that we lived on the same street. And that's about it.

Q What other lawyers did you know socially at that law firm?

A That's all I knew socially.

I've known Mr. Bonezzi for many years --

Q How many years?

A -- but professionally, only.

What would you say, Bill, about 10 years, 15 years?

Q Since I don't have Bill under oath, he won't answer that question, I'm sure, but --

A I don't know. Maybe in the neighborhood of 10, 15 years. Maybe 10 years.

Q Have you ever played golf together?

A I think maybe once or twice together, usually related to he'll come out here and I'll see him -- Once.

In Cleveland, and I believe we were doing a case together, and we played golf; not very

often, unfortunately. I wish we played more together.

Q Have you ever had your license or privileges suspended or restricted in any way?

A No.

Q Are there any opinions that we haven' discussed here today that you believe might be important in terms of your total understanding of this case?

A No, I think they've been pretty well expressed.

I just don't think Dr. Sawkar did anything wrong.

Q I fully appreciate that belief on your part.

MR. HAWAL: I don't have anything further.

Tom, you can have as much time as you need. I'm done.

MR. ALLISON: All right. Thank you.

EXAMINATION

BY MR. ALLISON:

Q Dr. Pitluk, just a couple of quick questions.

As Mr. Hawal just asked you, you know,

we've pretty much discussed all of your opinions that you've formulated on this case; is that correct?

A Yes.

Q And is it fair to say, then, that you have no opinions which would be critical of the residents or the nurses at Fairview General Hospital?

A Correct.

MR. ALLISON: Thank you, Doctor. That's all I have.

MR. HAWAL: Okay.

MR. BONEZZI: Tom, hang on because 1 want to talk to you for a moment.

(At the hour of 2:25, the deposition was concluded.)

HOWARD CHARLES PITLUK, M.D.

STATE OF ARIZONA)
) ss:
COUNTY OF PIMA)

BE IT KNOWN that I, Carol A. Post, took the foregoing deposition pursuant to notice at the time and place stated in the caption thereto; that I was then and there a Notary Public in and for the County of Pima, State of Arizona; that by virtue thereof, I was authorized to administer an oath; that the witness before testifying was duly sworn to testify the truth, the whole truth, and nothing but the truth; that the testimony of said witness was reduced to writing under my direction and the foregoing pages contain a true and correct transcription of my notes of said deposition.

I FURTHER CERTIFY that I am not of counsel nor attorney for either or any of the parties to said action or otherwise interested in the event thereof, and that I am not related to either or any of the parties to said cause.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my seal of office this 24th day of July, 1997.

Carol A. Post
Notary Public