IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

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DOC. 360

LINDA PAINO, Plaintiff

VS

RAGHU SAWKAR, M.D., ET AL, Defendants

No. 300909

. . . . . .

DEPOSITION OF HOWARD PITLUK, M.D.

September 10, 1997

Tucson, Arizona

. . . . . .

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A P P E A R A N C E S

* * * * *

SPANGENBERG, SHIBLEY, LANCIONE & LIBER

By William Hawal, Esq.

For the Plaintiff

ARTER & HADDEN

By Jeffrey A. Healy, Esq.

For the Defendant, Fairview General Hospital

JACOBSON, MAYNARD & TUSCHMAN CO., L.P.A.

By William D. Bonezzi, Esq.

For the Defendants, Dr. Sawkar,

Cleveland Vascular Surgery Assoc., Inc.

Also Present: Robbie Colville, The Video Technician

BE IT REMEMBERED that pursuant to notice the deposition of HOWARD **PITLUK,** M.D., was taken at the offices of Howard Pitluk, M.D., 1925 W. Orange Grove, #101, in the City of Tucson, County of Pima, State of Arizona, before Sherri **K.** Williamson, a Notary Public in and for the State of Arizona, on the 10th day of September, 1997, commencing at the hour of 9:35 a.m. on said day, in a certain cause now pending in the Court of Common Pleas, Cuyahoga County, Ohio.

DEPOSITION OF HOWARD PITLUK. M.D.

I N D E X

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E X H I B I T S

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(Exhibits 1 and 2F not attached.)

(Exhibits 1 and **2A** through **2L** previously marked for identification.)

HOWARD **PITLUK**, M.D.,

having been first duly sworn to state the truth, the whole truth, and nothing but the truth, testified on his oath as follows:

MR. BONEZZI: Let the record show that this is the deposition of Howard Pitluk, M.D., taken for purposes of preserving his testimony for an upcoming trial presently scheduled for September 23rd, 1997.

EXAMINATION

BY MR. BONEZZI:

Q. Would you state your full and complete name, please?

A. Howard Charles Pitluk.

Q. And your address, sir?

A. My business address is 1925 West Orange Grove, Tucson, Arizona.

Q. Do you have **a** profession?

A. Yes, sir.

Q. What is it?

A. I'm a general surgeon and a vascular surgeon, both.

Q. Doctor, would you be kind enough to provide us a little bit of insight relative to your educational background commencing with undergraduate school and bringing -- bringing us right up to the present?

A. I did my undergraduate at Northwestern University in Evanston, Illinois, receiving my bachelor's degree in 1971. I then went to the Ohio State University College of Medicine where I obtained my M.D. degree in 1974. And from there I went to the Northwestern University Medical Center in Chicago, Illinois, where I did a general surgical residency for five years, finishing in 1979.

Q. And since that period of time, have you furthered your education by attending courses, et cetera?

A. Yes. Many, many times.

Q. Now, you indicated just a moment ago that you are both a general surgeon and a vascular surgeon. Please explain to us the difference, if there is any.

A. Well, all vascular surgeons have to be general surgeons first. General surgery is the

discipline or the specialty whereby you take special training to learn how to perform operations on the body, usually confined to the abdomen, sometimes to the extremities and to the neck. The chest is usually excluded in general surgical practices.

Then you do additional training or during the course of your general surgical training you take extra courses that allows you to operate on the vascular tree, primarily the arteries of the body, so that one can perform surgery if these arteries become diseased.

Not every general surgeon does vascular surgeon -- does vascular surgery, and not every vascular surgeon does general surgery. I do both.

Q. And, Dr. Pitluk, can you tell us approximately how much time you spend actually performing duties relative to vascular surgery as opposed to general surgery?

A. My practice is devoted primarily -- can be divided into general and vascular surgery approximately 50/50.

Q. Now, speaking of vascular surgery for a moment, are you familiar with doing bypass grafting of vessels?

A. Yes.

What is that, please, as it relates specifically to vascular surgery?

A. When you have a vessel that becomes occluded or severely diseased, very often you need to bring blood flow down to below where the occlusion takes place. That's the term "bypass."

We do this in arteries of a leg, primarily. Also, however, in arteries of the abdomen, such as the aorta, where one brings a conduit or a graft or depending, if it's a regular vessel or a synthetic vessel, from an area where there is good blood flow around an area of occlusion or obstruction to an area where the blood flow can be reestablished. Thus, the term "bypass."

Q. Have you in your practice performed any procedures on the superficial femoral artery --

A. Many times.

Q. -- or popliteal --

A. I'm sorry.

Q. -- or tibial?

A. Yes to all three.

Q. And just for general purposes, would you explain to the ladies and gentlemen of the jury where the SFA, or superficial femoral artery, popliteal, or tibial artery are located, please?

A. The superficial femoral artery is the artery in the thigh, and it starts below the groin crease and continues on down to the knee joint.

At that point, the same artery is renamed the popliteal artery. The artery continues below the knee joint into the lower leg, and vessels -- three vessels actually come off of this one vessel, and these are the tibial vessels.

Q. Is that known as the trifurcation?

A. Correct.

Q. Okay. Let's go back for a moment to -- to your background. You are familiar with the term "board certification," are you not?

A. Yes, I am.

Q. And could you tell us what that is, please? And, most importantly, tell us whether or not you're board certified in your area of specialty.

A. Yes. Board certification applies to a -- a rigorous examination given after one finishes an accredited surgical residency program or any residency program -- I'm going to speak to surgical board certification at the moment -- and after one completes his residency, takes an -- both a written and an oral examination, which then is sanctioned by

a governing board called the American Board of Surgery.

Once this is done, you are board certified to perform your specialty with a high level of expertise. And in my particular case, I am board certified and, in addition, I have taken a -- a second examination ten years after my first -- or approximately ten years after my first where I am now recertified as well.

Q. And that recertification occurs what? Every ten years?

A. Approximately every ten years, correct.

Q. Dr. Pitluk, you are licensed to practice your specialty, are you not?

A. Yes.

Q. What state or states are you licensed to practice in?

A. I am licensed to practice in Ohio, in Arizona, and in California.

Q. And -- Excuse me. Can you tell us approximately how much of your professional -- professional time is spent in the active practice of medicine, clinical practice of medicine?

A. Essentially, 99 percent of it.

Q. Are you a member of any organization or

organizations relative to your field of specialty? And, if so, what?

A. Yes. I am a member of the American Board of Surgery. I'm a fellow of the American College of Surgeons. I am the past President of the Cleveland Vascular Surgical Society. I am the -- a member of the Society for Clinical Vascular Surgery. I am a past member of their executive committee. I am a member of the American Medical -- of the County Medical Association and the Local Medical Association. I believe -- I'm also a member of the Midwestern Vascular Surgical Society, and I believe that's pretty current.

Q. Dr. Pitluk, we are presently at your office in Tucson, Arizona; is that correct?

A. Correct.

Q. How long have you been here?

A. Two years.

Q. And from -- Where did you come from?

A. I came from Cleveland, Ohio.

Q. And did you practice medicine in Cleveland?

A. Yes, I did.

Q. For how long did you practice medicine in Cleveland?

A. I practiced from 1979 until August of 1995.

Q. You are currently privileged to practice your specialty in this area, are you not?

A. I think I am, yes.

Q. And as far as privileges at different institutions, can you tell us what institution or institutions you have privileges at?

A. Yes. I am currently on the active staff of Northwest Medical Center, which is a hospital here in Tucson. I am also on the active staff of the Tucson Medical Center, and I have courtesy privileges at St. Mary's Hospital here in Tucson.

Q. When you were in Cleveland, did you have privileges to practice your field of specialty?

A. Yes, I did.

Q. Where?

A. I was on the staff of the Hillcrest Hospital of Cleveland. I was on the staff of the Mount Sinai Hospital of Cleveland, the -- the staff of Parma Community Hospital, the staff of St. Mary -- Marymount Hospital, and I was on the teaching staff with a clinical appointment at the University Medical Center. That's Case Western Reserve University, where I was an Assistant

Clinical Professor of Surgery and taught at the Veterans Administration Hospital.

Q. Dr. Pitluk, in your practice either as a general surgeon or in the field of vascular surgery, have you become familiar with the term "balloon angioplasties"?

A. Yes.

Q. And tell us what that is, please.

A. A balloon angioplasty is, basically, a procedure whereby if you have a -- an occlusion or a severe narrowing of an artery, a balloon device is passed through the skin into the artery under x-ray control, and the balloon is inflated in the area of narrowing or occlusion to dilate this -- open up this area.

Q. And can you tell us what area of specialty or what, I guess, service performs balloon angioplasties?

A. Basically, there are three different specialties that perform this procedure. Radiology is one. A vascular surgeon is another. And cardiology is the third.

Q. So, in other words, it's your understanding that vascular surgeons do, indeed, perform balloon angioplasties; is that correct?

A That's correct

Q And the balloon angioplasties, from your knowledge or understanding, would be performed in what area of the body relative to the specialty of vascular surgery?

A Primarily, they are performed in the iliac vessels, which are the arteries that are going down into the legs, into the upper legs, and into the superficial femoral arteries, which are the arteries I described before, and occasionally, also, into the popliteal arteries

Q Have you performed those procedures?

A Not really I've done one or two, but I don't do that on a routine basis, no.

Q. Now, you understand what this case is about, do you not?

A. I believe I do.

Q. And can you tell us to what extent, if at all, this case involves the use of a balloon in performing an angioplastic procedure of one of the vessels of Mrs Paino s left leg?

A That was the original -- The balloon angioplasty was the original procedure performed on Mrs Paino in an attempt to revascularize the leg to a -- to a better degree than it presently was

Q Given the fact that you have only done one or two procedures involving a balloon angioplasty, do you feel competent in providing testimony relative to the areas involving this case?

A Oh, absolutely Mainly because I send my patients for balloon angioplasties all the time The reason I don't perform them myself is, basically, I have too much else to do, and I feel radiologists are perfectly competent, in my particular situation, to perform these procedures, provided I'm in attendance, standing by, available to perform whatever is necessary if they are unsuccessful.

Q So, in other words, even though you do not personally attempt to do balloon angioplasty other than what you have just indicated, you are actually present at the time in which these are being carried out by the invasive radiologists?

A Sometimes, although I don't need to be I'm always available The standard of care in the community states that if a balloon angioplasty is going performed by someone other than a vascular surgeon, the vascular surgeon must first be consulted on the case and be available to perform surgery, if indicated, if there is a complication or

a problem. And, moreover, he really is the person who makes the decision if a balloon angioplasty needs to be performed.

Q. Are you familiar, Dr. Pitluk, with the indications for performing balloon angioplasties for the superficial femoral artery?

A. Yes.

Q. Before we get into this case, there's some terms I want to discuss very briefly. Are you familiar with the term "ABI" or "Ankle/Brachial Index"?

A. Yes.

Q. What is it?

A. The Ankle/Brachial Index is a number that is derived by doing what is called a noninvasive study, sometimes referred to as a Doppler study, whereby one measures the blood pressure -- the systolic blood pressure in the ankle of the individual, and, usually, it's either the posterior tibial or the dorsalis pedis blood pressure -- it means they're arteries at the ankle level -- and takes that number and compares it to the systolic blood pressure in the arm, which is your normal blood pressure.

A ratio is derived, and that ratio should

be one. In other words, the blood pressure in your ankle should be the same as the blood pressure in your arm. If there's a deviation below one, this number gives you an indication as to degree of vascular occlusion in the leg.

Q. Are you familiar with a PVR study? And, if so, tell us what it is and what the initials "PV," as in Victor, "R" represent.

A. Yes. A PVR is called a Pulse Volume Recording, and, essentially, this is a tracing of the blood flow to the extremity, which is corroborated and can correlate very well with the actual amount of blood getting into the extremity.

The pulse and volume are directly proportional according to the resistance, according to a law of physics, basically, and the tracing will tell you what volume of blood is getting into an area. Obviously, if there's blockage of the flow into that area, the volume will be decreased, as one would expect.

And so looking at these tracings, one can get a reasonably good idea as to the amount of blood getting to an area. And then combining that with the information obtained from the ABI, or the Ankle/Brachial Index, one has a reasonably good

assessment as to the blood flow to a particular area.

Q. Are you familiar with the term "claudication"? And, if so, what is it?

A. Yes. Claudication, in this particular instance, refers to -- actually, the term is "vascular intermittent claudication." That's the proper -- That's the full name. And claudication is pain produced with walking in a -- in a leg, usually in the calf, which stops when one stops walking and then is reproduced when one walks the same distance.

Q. To what extent, if at all, can a physician obtain information from either a PVR study or an Ankle/Brachial Index study to determine whether or not there is any type of stenosis or narrowing of any of the vessels in the lower extremities?

A. Well, as I indicated, it's a very good way to determine the -- the amount of claud -- of occlusion in -- in the areas in question.

Q. Can you tell us whether or not there is an association or a relationship relative to the numbers of a PVR or ABI study and claudication?

A. Yes. There are numbers that determine some criterion. As I stated before, one or slightly

less than one, .9, is the number which indicates an essentially normal arterial tree.

When you get below that, we begin seeing claudication, and, usually, significant claudication occurs at approximately .75. Below .75, the lower you go, the more the claudication, the shorter the distance one must walk before the pain occurs.

When you get to a level of approximately .4 or 5 -- you usually will not heal a below the knee amputation if you're much below that, .4 to .45. At approximately .25, one begins to see ischemic what we call rest pain, which means that at night, when the extremity is elevated, because one loses even the small amount of blood flow that gravity provides when the foot is on the floor, pain occurs, requiring the individual to put their foot on the floor most -- most of the time during the evening. And then at below .2, we actually start seeing tissue changes, such as gangrene.

Q. Dr. Pitfuk, at my request, did you review certain records in this case involving Mrs. Paino's involvement with Dr. Sawkar and a subsequent hospitalization at Fairview General Hospital where certain surgical procedures occurred?

A. Yes, I did.

Q. And can you tell us whether or not the material that I provided to you, which I believe included deposition testimony and reports from various individuals, provided you sufficient information in which you were capable of forming opinions or drawing conclusions relative to the care that was provided to Mrs. Paino by Dr. Sawkar?

A. Yes. I was able to.

Q. And can you tell us whether or not the information that I gave to you enabled you to determine whether or not, first of all, Dr. Sawkar met the acceptable standards of care for a vascular surgeon --

A. Yes.

Q. -- and, secondly, whether or not he actually met the standard of care?

A. Yes on both accounts. I felt that there was information sufficient to obtain an opinion, and the opinion is that he did meet that care.

Q. Can you also tell us whether or not, in your review of records that I provided, one of the documents included Dr. Sawkar's actual office records?

A. Correct.

Q. And within the office records and the other records that I provided, can you tell us whether or not you were able to review and did you review the interpretation from the PVR studies and, also, the Ankle/Brachial Index studies that were carried out?

A. Yes, I did.

Q. Did you also review the arteriogram that demonstrated whether there was stenosis in any of the vessels of the lower extremity or occlusions in the vessels of the lower extremity on both the right and the left side?

A. Yes. I reviewed the reports of the arteriogram.

MR. BONEZZI: Okay. May we go off the record, please?

MR. HAWAL: Certainly. I'm sorry.

(A discussion was held off the record.)

Q. We're back on the record. Dr. Pitluk, I handed to you, by way of Mr. Hawal, at the break two documents that are part and parcel of the Fairview General records that will encompass a period of time between, I believe, February 8th -- in fact, it'll -- the one document will take you back to January 30th of 1995, and the other one is a

subsequent document, I think, February 8th of 1995.

Would you tell us what those two documents represent, please, using the dates on each of those, please? The one on the left first.

A. The one on the left is dated 01/30/95, and it is a resting PVR study interpretation. And this was --

Q. And the one on the --

A. I'm sorry.

Q. I'm -- Go ahead. I apologize.

A. It was -- It was dictated by Dr. Sawkar, and the date of -- the date of dictation was 02/03/95.

Q. Excuse me. And the one to the right of that?

A. The one to the right is labeled "Fairview General Hospital Vascular Lab," and it's a lower arterial study. The date on this is also 01/30/95.

Q. And what does that represent?

A. And this represents the actual Ankle/Brachial Indeces obtained both at rest as well as after exercise with a -- a time and a grade, which is the degree of inclination the patient was walking upon when the study was performed.

Q. And can you tell -- excuse me -- can you

tell us whether or not -- excuse me -- on the study, the ABI study, if there are numbers or indicators relative to a study done at rest and then a study that was done by way of exercise?

A. Yes, there are.

Q. Well, first of all, explain to us what the difference is, if there is one, between the value that one receives in a test such as this relative to numbers at rest as opposed to the numbers obtained following or during exercise,

A. The numbers at rest give you a baseline as to the amount of blood flow getting to an extremity when it is at rest; in other words, when one is standing still or sitting down or lying down. That number is a value because it does give you the baseline.

However, when one walks, the -- if the numbers decrease, that is telling you that there is a significant narrowing or occlusion in the artery that does not allow sufficient blood to get to the extremity that is being measured and pain is produced.

One must understand that blood is the carrier of oxygen. Oxygen is food for the muscle. And so when you walk and you develop pain, that's

because you're not getting enough oxygen via blood to the muscle. And the only reason that occurs in these situations is when there are significant narrowings in the blood vessel.

So even though your number at rest may be as -- an adequate level, when you start walking and the number drops, that corroborates the -- the fact that you are developing claudication, and the lower the number drops, the more significant the claudication.

Q. To what extent, if at all, would a balloon angioplasty be an appropriate procedure to perform on behalf of an individual who, indeed, has either stenosis of certain vessels or evidence of claudication by way of those records?

A. It's very often the preferred method.

Q. Why is it preferred?

A. Because it's much less invasive insofar as the patient is concerned. It's a needle stick versus a -- a -- an actual incision or an operation, does not require a general anesthetic, and when it can be performed successfully, it just allows the patient to be, basically, cured immediately with very little morbidity, very little hospital stay, very little discomfort afterwards, very little

recovery, and it would give you the same result, which is increased blood flow to the area in question.

Q. Did the records that I provided to you set forth any history relative to Mrs. Paino's underlying clinical condition --

A. Yes.

Q. -- prior to these studies?

A. Yes, they did.

Q. To what extent were you able to derive information relative -- relative to her cardiac status?

A. To a great extent.

Q. And can you tell us to what extent, if at all, a physician such as yourself takes into consideration the underlying clinical status of a patient when determining what type of procedure may be best for that patient relative to, for instance, stenosis of vessels of the lower extremity?

A. As a vascular surgeon, we operate upon elderly individuals all the time. It's important to understand that we're not just operating on a leg or on a neck; we're operating on a person. And so a -- a trained vascular surgeon, as any good physician, takes into account the entire condition of the

patient in making a decision as to what's the best modality of treatment for that patient in a particular situation, and I believe that's what applied here.

Q. Okay. Now, I want you to take a look at the document that's to your right, which will be the information pertaining to the Ankle/Brachial Index. And I think at the bottom of that document will be some numbers and information relative to the exercise that was employed relative to Mrs. Paino. Do you see that?

A. Yes, I do.

Q. First of all, can you tell us what exercise was requested of Mrs. Paino at the time in which this test was done?

A. She was just asked to walk on a treadmill at a very minimal elevation.

Q. When you say "minimal elevation," can you tell us if that document sets forth degree of elevation?

A. Yes, it does. It says 10 degrees of elevation.

Q. Okay. Now, use your hand, if you would, please, and have it level, which will indicate 180. Can you go ahead and show us by way of the tipping

of your hand approximately what 10 degrees would be?

A. If this is level, 10 degrees is perhaps like this. (Indicating.)

Q. And can you tell us whether or not the document provides any information relative to the speed in which the test was being conducted?

A. Yes, it does.

Q. What?

A. It says that the rate was 1 mile per hour.

Q. Can you tell us what the normal rate of speed would be for an individual who was walking normally?

A. Usually, it's around 3 to 4 miles an hour.

Q. So, in other words, this test that was conducted on behalf of Mrs. Paino or one in which she participated in was at a speed of approximately 1 mile per hour, according to that document, at a -- at a rate or a level of approximately 10 degrees above level; is that correct?

A. Correct.

Q. Does that document also provide information relative to when, if at all, she experienced pain?

A. Yes, it does.

Q. What is it?

A. At 1 minute.

Q. Based upon the numbers there, first of all, can you tell us whether there is any indication that she would have stenosis in either the right or left lower extremity at rest?

A. Yes, there is.

Q. And can you tell us whether or not the numbers remain the same or change in any appreciable fashion following the employment of exercise?

A. They do change dramatically after exercise.

Q. Tell us the significance, if you would, please, of the changing of those numbers.

MR. HAWAL: Objection.

Q. You may answer, Doctor.

A. I stated earlier the numbers showed dramatic decrease in the actual Ankle/Brachial Index after exercise at 1 minute, and, actually, immediately is the way the term is used on this form, to a level that is quite critical both on the right and the left, "critical" meaning that the patient should be experiencing severe pain in a very short period of time, which is almost limb

threatening in -- on the right side and severely incapacitating on the left.

Q. To what extent, if at all, would you as a physician take into consideration the history that is provided to you by a patient in attempting to determine what is the underlying problem?

A. Well, the history is actually the most important thing we do. ***So,*** to that extent, we take it very seriously into consideration.

Q. Now, you reviewed Dr. Sawkar's office records, did you not?

A. Yes, I did.

Q. By the way, when did Dr. Sawkar first see Mrs. Paino in relationship to the two documents sitting in front of you?

A. In relationship to this document, it would have been around January of **1995**.

Q. And when did he see her in the office for the very first time?

A. I believe it was in **1993**.

Q. Can you tell us whether or not the documents that were generated from her presentation to his office in **1993** provide any information relative to the presence of either superficial varicosities in both of the extremities or phlebitis

or thrombophlebitis in either one of the extremities?

A. Yes. They -- It -- It indicates that she had superficial thrombophlebitis in both lower extremities.

Q. And can you tell us to what extent, if at all, the presence of thrombophlebitis will have an impact on the saphenous vein of both extremities?

A. Well, usually, that is the vein involved with the superficial thrombophlebitis.

Q. Okay.

A. And it -- it actually occludes the vessel.

Q. When you say "occlude," what do you mean?

A. It means the blood is no longer flowing through it and the vessel is, basically, what we call thrombosed or sclerosed, no longer as a conduit.

Q. And can you tell us, based upon the records you reviewed, if there was a history of underlying cardiac disease or cardiac abnormalities with Mrs. Paino?

A. Mrs. Paino actually had had a cardiac bypass prior to being seen in 1995. I believe it was in '94 at the Cleveland Clinic Foundation.

Q. And can you tell us if there is a relationship or an association between the presence of some type of atherosclerotic condition in the lower extremities as opposed to atherosclerosis that would dictate or demand that intervention be done on behalf of a patient for cardiac abnormalities?

A. Yes. Atherosclerosis is a systemic disease. It doesn't just affect one artery. It affects all the arteries. So the same disease process that caused her coronary arteries to be bypassed also caused her femoral -- superficial femoral arteries and other arteries to become diseased with the same -- with the same atherosclerotic changes.

Q. Now, Dr. Pitluk, can you tell us whether or not the PVR study or the ABI interpretation will provide degrees of stenosis or occlusion relative to the vessels of the lower extremity?

A. Yes, as I indicated before.

Q. Well, will it provide you specific information or do you have to get another study to determine whether or not there is the presence of complete occlusion or partial stenosis?

A. Yes. The -- The A -- The ABI and the PUR studies are good indicators of disease, as I spoke

to, but if we want to know exactly where the problem is, we need an actual picture of the artery, and that picture is obtained with an angiogram, which is an x-ray where dye or contrast material is put specifically into the artery and a picture is taken where the arteries actually show up on x-ray.

Q. Now, there is two more documents that are sitting right above the PVR study, right up at the top, right there. Can you tell us what those documents represent? And I will tell you that they would have been part and parcel of documents that would have been generated relative to her presentation to Fairview General Hospital, I believe, on February 8th of **1995**.

A. These are reports of the arteriogram that I just described where one opacifies the arteries done on February 8th, **1995**, at Fairview General Hospital by Dr. Sawkar.

Q. And just briefly tell us what the result of that test was relative to the extremities.

A. This test confirms the fact that Mrs. Paino had severe blockages and arteriosclerosis obliterans of the arteries of both lower extremities, both legs.

Q. By the way, can -- do you know if

Mrs Rhino had any type of arthritic condition, according to the records you reviewed?

A Yes I'm -- She has had severe arthritis of her -- general arthritis in particularly her left knee.

Q And can you tell us whether or not the presence of arthritis, if you know, will cause any type of problem in ambulating or walking?

A Yes It's just as all know that it does

Q And to what extent, if at all, would the association of stenotic vessels -- will that have an impact on the ability of a patient to -- or person to ambulate?

A. Of course That's clarification.

Q Together with arthritic changes?

A Well, they're additive

Q Okay Now, can you tell us, if you would, please, and take a look at the second page of the arteriogram and tell us whether or not there is any mention, first of all, of the degree of involvement of the vessels and then whether or not Dr Sawka had any recommendation relative to how to correct the problem?

A Yes to both questions, and --

Q It would be on the second -- yeah, the

second page.

A. Which leg do you want me to address? Both?

Q. Yeah. Why don't you do that.

A. The study, basically, just says that the right superficial femoral **is** occluded in the mid-thigh and re-opens through collaterals from the profunda above the knee. The left side has a high grade stenosis in the femoral and popliteal junction. He says 90 to 95 percent, which can be ballooned. So he indicates that he feels that this particular lesion on the left side is amenable to balloon angioplasty.

Just below the knee, and we're still on the left side, the popliteal trifurcation is occluded, but the tibial vessels reform the collaterals. The right-sided two vessel run-off is noted, and right fem-pop will not be done unless the claudication becomes disabling or rest pain develops.

Q. Now, according to Dr. Sawkar's records, can you tell us whether or not there was any conversation that ensued between Dr. Sawkar and Mrs. Paino pertaining to what Dr. Sawkar had recommended for her following the information gained

from the arteriogram?

A. Yes.

Q. What?

A. I believe his indications in the records were that he wanted to perform a balloon angioplasty on her because that would be amenable to her condition.

Q. And can you tell us whether or not you have formed an opinion, based upon reasonable medical probability, whether the decision -- the recommendation that Dr. Sawkar gave to Mrs. Paino relative to the involvement of a balloon angioplasty was an appropriate one? Do you have an opinion?

A. Yes, I do.

Q. And what is that opinion, sir?

A. My opinion is that it was a -- perfectly appropriate to perform a balloon angioplasty in this individual.

Q. Why?

A. For the same reasons that Dr. -- Dr. Sawkar indicated in his deposition, which is, basically, she had a lesion that was amenable to balloon angioplasty. She had a history of cardiac disease. She was an elderly woman who certainly did have severe medical problems and that the balloon

angioplasty would provide the least invasive method of obtaining blood flow to that lower extremity to alleviate her condition. So it would be the safest for the patient.

Q. Dr. Pitluk, as part of the records that I provided to you, can you tell us whether one of the records was a report by a Dr. Porter, who is also a vascular surgeon from Portland, Oregon?

A. Yes. There was a brief report by Dr. Porter.

Q. Dr. Pitluk, I want you to assume for purposes of this question that Dr. Porter has numerous opinions, one of which was that the condition of Mrs. Paino did not represent something that warranted any type of intervention, including a balloon angioplasty. I want you to assume that as being fact.

Based upon your review of the records and based upon your review of the studies, do you have an opinion, based upon reasonable medical probability, whether or not the intervention alone of a balloon angioplasty was warranted? Do you have an opinion?

A. Perhaps I misunderstand you. Is this --

Q. This is Dr. --

A -- my opinion or Dr. Porter's opinion?

Q No. This is your opinion.

A Oh Well, my opinion is the same as it -- as I just stated, that this intervention was indicated

Q. Ultimately, what did Dr. Sawkar do on behalf of Mrs Paino following the February 8th arteriogram?

A He ultimately gave her some options regarding revascularization of both balloon angioplasty or bypass Mrs Paino apparently contacted Dr. Sawkar approximately two to three weeks later and indicated that she wanted something done on her left leg because her pain was getting worse, and Dr. Sawkar performed a balloon angioplasty on the 27th of February at Fairview General Hospital on the left leg.

Q Any complications arise relative to the balloon angioplasty that you're aware of?

A. Unfortunately, yes

Q. What?

A. There was an apparent dissection and extravasation or rupture of the superficial femoral artery after the balloon angioplasty There was at least an occlusion of the superficial femoral

artery. Whether it was extravasation or dissection is sort of irrelevant. There was an occlusion.

Q. Now, did you, by any chance, review the operative note relative to the balloon angioplasty that was dictated by Dr. Sawkar and also by the resident, Dr. Siebert?

A. The two different notes?

Q. Yes, sir.

A. Yes, I did.

Q. And there -- there are two different notes, but are they notes relative to the same procedure?

A. Yes, they are.

Q. And can you tell us whether or not there is any record relative to their belief or their opinion of whether or not there was, in fact, free flow of blood between the area in which was ballooned to a lower segment?

A. Yes. They both believe that there was free flow, and their indications were a palpable popliteal pulse, a Dopplerable, that is to say audible pulses by use of an augmented listening device in the ankle areas and that all indications on both reports were that there was adequate flow and a successful balloon angioplasty.

Q Assuming that to be correct, was it then appropriate for Dr. Sawker and, to that extent, Dr Sievert then to go ahead and transfer the patient from the OR to either the recovery room or to whatever other place they were going to send her?

A Yes, it was

Q Now, subsequently, can you tell us whether Dr. Sawker was then notified by any personnel from Fairview General Hospital relative to a complication that was detected?

A Yes.

Q What happened?

A Apparently, while he was driving home from this procedure, he was notified that Mrs Pino's leg had become cool and mottled and she was in pain and that there was an obvious problem with the balloon angioplasty

Q What did he do, if anything?

A. He came back to the hospital and did an immediate bypass.

Q Do you have an opinion, based upon reasonable medical probability, whether or not the actions of Dr. Sawker up to this point met acceptable standards of care for a vascular surgeon?

A Yes, I do

Q. What is it?

A. They were totally within the acceptable standards.

Q. Have you reviewed the operative note of Dr. Sawkar that was either dictated or at least set forth as a result of his second intervention with Mrs. Paino on the 27th of February, 1995?

A. Yes, I have.

Q. And can you tell **us** whether or not that operative note sets forth what Dr. Sawkar's involvement was with Mrs. Paino?

A. Yes, it does.

Q. And to what extent, if at all, were you able to gain information or knowledge relative to whether he did a further balloon as opposed to a bypass grafting procedure?

A. Well, he did a further bypass, the balloon --

Q. What did he do?

A. He did a bypass procedure, and the note is quite clear that he did this bifur -- bypass procedure below the occlusion in the trifurcation of vas -- that he described in his arteriogram and placed a synthetic graft from her femoral artery, which is in the groin, around the occlusions of her

superficial femoral artery down to the tibial peroneal trunk, where the artery was soft and able to be bypassed.

Q. Dr. Pitluk, do you have an opinion -- and from this point on, I'm just going to have you assume that all of my questions pertaining to opinions include that those opinions are within a reasonable degree of medical probability. Would you do that for me, please?

A. Yes, sir.

Q. Okay. Can you tell us if you formed an opinion in this case relative to the initial procedure that was done, i.e., the balloon angioplasty, and whether or not the dissection or the occlusion, whatever it may have been, is a complication of the type of procedure that, in fact, was done by Dr. Sawkar?

A. Yes, I do.

Q. Is it a recognized complication within the field or circle of vascular surgeons?

A. Oh, absolutely.

Q. Now, when you talk about or I talk about and I ask you relative to questions involving recognized complications, explain to the ladies and gentlemen of the jury what a recognized complication

of a surgical procedure happens to be.

A. Unfortunately, when we do surgery, it's -- there's an art involved as well as the science, and you don't always get a perfect result. Perfect results do not -- or -- or lack of perfect results do not mean negligence nor do they mean that one is performing below the standards of care in the community.

We often see complications that are recognized, and the major recognized complication of a balloon angioplasty is failure of the procedure to do what you are trying to **do**, which is open up the vessel, and this failure often is a dissection. In fact, the method of operation of a balloon angioplasty is to cause a rupture of the lining of the artery, which causes a dissection. We actually want a controlled dissection.

Sometimes, however, the dissection will lead to occlusion. The artery will become clotted by the blood that's flowing through it because of the procedure performed. This is a recognized problem that happens, and one needs to be attuned to it.

So a recognized complication is: Of any operation, there are things that sometimes don't go

according to the way you want them to go. And this -- in a balloon angioplasty, dissection and/or rupture and/or occlusion are seen as the three most common complications.

Q. I forgot to ask you if you were able to determine from Dr. Sawkar's February 16th, 1995, office note what his intended purpose was in doing the balloon angioplasty.

A. Yes. I believe his purpose was to try to increase the blood flow to the knee area through collaterals because of her arthritis and a possible impending arthritic operation.

Q. And do you recall, from reviewing Dr. Sawkar's office note, that note stating that he would do the left superficial femoral artery balloon angioplasty to improve collateral circulation; do you recall that?

A. That -- That's what I just said.

Q. What is a collateral?

A. When you have an area of occlusion in an artery, think of it as a main street. Being familiar with Cleveland, think of Euclid Avenue, and if that's the main artery that takes you downtown, if Euclid Avenue is blocked, you need to get downtown, well, there are other ways to get

downtown, and that's what we would call a collateral artery or a collateral street.

It's a street that'll take you parallel around the blocked area and then get you in maybe lower down on Euclid Avenue or onto a different street to downtown.

In the arterial system, it's exactly analogous. If you have a blockage in an artery, such as the superficial femoral artery, there are other little side streets that will get blood around the blockage down to where you want to go; in this case, the lower leg.

That's the reason why, even though the major artery is blocked, you don't develop gangrene, necessarily, nor do you even develop vascular problems, because enough blood is going through these side streets, if you will, to keep the extremity viable and pain free.

THE REPORTER: Just a minute.

(A discussion was held off the record.)

Q. Dr. Pitluk, in the absence of an occlusion or stenosis of a major vessel, are collaterals always there or do collaterals form as a result of stenosis or occlusion?

A. They're always there, but they actually

will get bigger because of the stenosis and occlusion.

Q. Okay. Now, going back to the second procedure on the 27th of February, what did Dr. Sawkar do?

A. He went in and performed a bypass operation using a synthetic graft.

Q. Gore-Tex?

A. Gore-Tex.

Q. Now, in that situation, can you tell us whether or not it was acceptable to use a Gore-Tex graft as opposed to the patient's own vessel, such as a saphenous vein, autologous vessel?

A. Yes. It was acceptable, perfectly acceptable.

Q. If the physician who is doing a procedure such as this, a bypass of an area of occlusion, and that physician believes that there has been a history of thrombophlebitis, to what extent, if at all, is that taken into consideration when attempting to determine whether a synthetic graft should be used as opposed to the patient's own vessel or autologous vessel?

A. It's extremely important because --

Q. Why?

A -- because, as I indicated earlier, the thrombophlebitis causes occlusion and/or narrowing of this conduit, this saphenous vein that you want to use for the bypass, and it's -- it's critical that that bypass be pristine; in other words, have no disease in it whatsoever. If there is disease in it, then you're basically replacing one bad artery with another.

Q. Can you tell us whether or not Mr. Sawkar, on the evening of the 27th, attempted -- prior to the use of a Gore-Tex graft, attempted to use an autologous vessel from rs Paino? And, if so, which vessel was it and on what side?

A It was the left saphenous vein. He did attempt to use it and found that it was diseased

Q Now, remember early on when I asked how if there was a history pertaining to thrombophlebitis?

A. Yes.

Q. Remember that?

A. Okay.

Q. And I believe you indicated there was a history relative to the -- excuse me -- right side.

A To both sides, correct

Q Now, to what extent should Mr. Sawkar, in

your opinion, have attempted to harvest the left saphenous vein -- strike that -- the right saphenous vein after already attempting **to** harvest the left saphenous vein and finding that there were abnormalities associated with that vessel? To what extent should he have then attempted to use the right in lieu of that history?

A. You mean, in -- because of the history?

Q. Because, not in lieu of.

A. Right.

Q. But in -- because of the history.

A. Yeah. I -- I think he was perfectly within the standards of care of the community to do what he did, which *is* not go to the right side and use an aut -- and use a synthetic graft, in this case Gore-Tex, to do the bypass.

Q. Up to this point, has he met the standard of care?

A. Yes.

Q. Now, where did he do the anastomosis or the joining together of the vessels? Explain to us proximally and then explain where the anastomosis was done distally.

A. Proximally, or up on top, he did it at the level just below the groin crease where the

common femoral artery becomes the superficial femoral artery, which is the appropriate spot. And then he went below the knee joint to an area below where the occlusion was in the trifurcation, as he described in his arteriogram in early February, found an area of the tibial peroneal trunk which was soft and plugged his graft in there.

Q. And was that appropriate, in your opinion --

A. Absolutely.

Q. -- to do the anastomosis distally in the area that you have just described, which would have been distal to the trifurcation?

A. Not only is it appropriate; that's where I would have put the -- the anastomosis, also.

Q. Should it have gone lower?

A. No. There was no reason to go lower.

Q. What happened then?

A. What happened then, apparently, was over the course of the next day, the graft occluded.

Q. And can you tell us whether or not it is common or uncommon for a Gore-Tex graft, in the face of what this patient has gone through, to occlude?

A. Common? What do you mean by "common"?

Q. Common or uncommon. Does it happen all

the time? Is it --

A. It happens --

Q. -- something that's rare?

A. It's a recognized complication.

Q. Can you tell us from the records approximately when the occlusion occurred?

A. It's hard to say, but I would imagine it occlude -- occluded sometime around 1:30 or 2:00 in the morning, perhaps a little later.

Q. And based upon these records, Dr. Pitluk, are you able to tell us when the second procedure finished --

A. I don't recall.

Q. -- what time of the night? Why don't you take a look at the anesthesia record, if you've got that, and tell us when. And the records are behind you.

A. Okay. Excuse me a moment.

Q. Just look at the anesthesia record.

A. Can I use this?

Q. Yeah. Please.

A. You'll have to excuse me, but there's a lot of different anesthesia records.

Q. It's the record for the procedure on February 27th.

A Right.

Q It would be the second one's commencing probably around 10:00 a.m.

A Right. And according to this, it finished at 10:50. Is this the one we're talking about?

Q Yes.

A Okay. That's what it says, 10:50 FT, which I mean -- I assume means finish time.

Q Okay. And it's your belief that the occlusion occurred subsequent to the spasm starting at anywhere from 1:00 to 1:30 in the morning or later or whatever?

A Or -- or later, yes.

Q Okay. Now, for purposes of this question, I want you to assume that there has been testimony provided by way of videotape deposition by a physician from the Cleveland Clinic, Edgar Wilborne, who is a neurologist by training but who conducts certain type of studies to determine whether or not nerves are damaged, et cetera.

I want you to assume that Dr. Wilborne has testified that studies that presently exist indicate that permanent nerve damage can occur from a lack of blood flow within a couple of hours. I

want you to assume that. I want you to assume that Dr. Sawkar did not see Mrs. Paino until the following morning, i.e., February 28th, 1995.

Based upon those facts as I have provided them to you and assuming that to be accurate as I have described it, do you have an opinion, based upon reasonable medical probability, whether or not by the time that Dr. Sawkar found -- saw Mrs. Paino, there has already been established permanent nerve damage to the left lower extremity? Do you have an opinion?

MR. HAWAL: Objection.

Q. You may answer, Doctor.

A. Yes.

Q. What is that opinion, sir?

A. That there probably was damage that already occurred by the time he saw her.

Q. Now, I'm going to ask you a question that I know somebody else will, but I'll do it first. After Dr. Sawkar saw Mrs. Paino on the morning of the 28th, should he have taken her back to surgery?

A. On the morning of the 28th?

Q. Yes.

A. I believe he should have, yes.

Q. And can you tell us to what extent the

failure of Dr. Sawkar to take her back to surgery for whatever he was going to do caused further damage --

A. I --

Q. -- to Mrs. Paino's left lower extremity?

A. I -- I don't think it probably made a difference at that point insofar as further damage is concerned.

And do you believe that there already was damage done to the left lower extremity as you have already described it?

A. Yes.

Q. Okay. Now, Doctor, can you tell us, taking everything into account, everything that we have gone over up to this point, whether or not up to the morning of the 28th of February, 1995, Dr. Sawkar met acceptable standards of practice for a vascular surgeon?

A. Yes. I believe he absolutely did.

Q. And do you believe that anything that he did or failed to do up to that point caused any injury to Mrs. Paino?

A. No. I mean, injury occurred, but he didn't do anything wrong, if that's what you're indicating.

Q. That's what I'm asking --

A. No.

Q. -- whether or not anything that he may have done was beneath the standard of care that ultimately caused injury to this patient.

A. No. Nothing he did was beneath the standard *of* care.

Q. And up to that point, he met the standard of care; is that correct?

A. Absolutely.

MR. BONEZZI: I have no further questions. Thank you.

EXAMINATION

BY MR. HAWAL:

Q. Dr. Pitluk, where did Dr. Sawkar obtain his training in peripheral vascular surgery?

A. I don't recall. I believe he did -- did some at -- in Cleveland at -- I think it might have been Lutheran or Fairview, but I'm not sure. I don't really know.

Q. You read his deposition, did you not?

A. Yes. I didn't pay attention to that, but --

Q. Have you been provided by Mr. Bonezzi

with a copy of Dr. Sawkar's curriculum vitae, which was previously marked as Plaintiff's Exhibit 1?

A. No. Or if I did, I don't recall it.

Q. Would you take a look at that?

A. (Reviewing document.)

Q. Where does that indicate that Dr. Sawkar represents that he obtained his training in peripheral vascular surgery?

A. Oh, that's right. The Marion clinic. I remember that now.

Q Smith Clinic?

A. P.C. -- Yeah. P.C. Smith Clinic in Marion, Ohio.

Q. All right.

A. Right.

Q. So Dr. Sawkar indicates that that's where he obtained his training in peripheral vascular surgery?

A. I recall that now. That's correct.

Q. He --

A. That was in his deposition.

Q. He testified that that's where he did all of his training with respect to balloon angioplasty procedures. Do you remember that?

A. I believe he said that he learned balloon

angioplasty there, yes.

Q. Have you been made aware by Mr. -- from Mr. Bonezzi since Dr. Sawkar's deposition that, in fact, he never did a fellowship in peripheral vascular surgery anywhere, let alone the P.C. Smith Clinic?

MR. BONEZZI: Objection. Go ahead and answer, Doctor.

A. No.

Q. And you indicated that you do not perform peripheral -- you do not perform angioplasty procedures?

A. No, I don't.

Q. And I believe you testified in your deposition previously that in all the institutions that you've been affiliated with and have had privileges at, those procedures are done by invasive radiologists.

A. Well, I -- for me, they are, yes. I mean, other people do them.

Q. All right. Cardiologists do them?

A. Yes.

Q. And vascular surgeons do them?

A. Some do, yes.

Q. Some do. Minority of vascular surgeons?

A. I -- I don't have a number on that.

Q. Is a cardiothoracic surgeon different in terms of the type of training that a cardiothoracic surgeon receives as compared and contrasted with a peripheral vascular surgeon?

A. Yes.

Q. Do you know if cardiothoracic surgeons receive any training in performing peripheral va -- peripheral vascular angioplasty procedures on the lower extremities?

A. I don't know if they do or they don't. I'm not familiar with any that do, but there may be some.

Q. Would you agree that an angioplasty procedure is considered a relatively safe procedure?

A. Yes.

Q. Is the likelihood of complication, such as rupture or dissection, something that is increased in the hands of a careless or inexperienced physician?

A. Well, I think careless always will create more complications. That's correct.

Q. What about an inexperienced physician?

A. Not necessarily.

Q. Is the risk of complication such as

arterial rupture or dissection during balloon inflation quite low, somewhere around 2 percent?

A. It's somewhere in the neighborhood of 2 to 5 percent.

Q. Would you agree that guide-wire dissection is often an avoidable complication that is related to operator inexperience?

A. No.

Q. Would you agree that rupture during balloon inflation is quite rare when appropriately sized balloon catheters are used?

A. Please define "quite rare."

Q. Quite rare, less than 1 percent?

A. Probably, that's correct.

Q. I notice that you have several vascular texts here in your office sitting behind you on a grouping of shelves. One is Rutherford's Text on Vascular Surgery?

A. Right.

Q. And that's Volume 1 of a two-volume set?

A. Yes. Volume 2 is, I think, at home.

Q. That is a text that's au -- that's edited by Dr. Robert Rutherford?

A. Correct,

Q. Could you tell the ladies and gentlemen

of the jury who Dr. Robert Rutherford is?

A. Professor of Surgery at the University of Colorado.

Q. And is Dr. Rutherford --

A. Vascular surgery. I'm sorry.

Q. Is Dr. Rutherford considered to be one of the preeminent authorities?

A. No. I mean, he's no more authoritative than -- than many, many other people.

Q. Is he more authoritative than you are?

A. It depends on who you ask.

Q. Anyone but you?

A. I don't think my wife would agree.

Q. Okay. Is his textbook on vascular surgily -- surgery highly respected and considered a reliable source for information on peripheral vascular surgery?

A. It's the -- like all -- all textbooks, and his textbook is not unique. It's a basis for the fund of knowledge that one uses.

Q. Do you know Dr. John Porter?

A. I don't know him personally. I know who he is.

Q. Do you know that he has been invited to write five chapters in Dr. Rutherford's Text on

Vascular Surgery?

A. I don't have any reason to deny that or dispute that.

Q. Do you recognize that his writings appear regularly in vascular surgical textbooks and the vascular surgical journals that you subscribe to and have sitting on your desk, such as the Journal of Vascular Surgery?

A. Sure.

Q. Doctor, you talked earlier about the con -- the angioplasty procedure that Dr. Sawkar performed. At the completion of an angioplasty procedure, is it customary or within the standards of care for a vascular surgeon or a invasive radiologist or whoever is performing the angioplasty procedure to do what is called completion angiography?

A. Yes.

Q. And what is the purpose? What is a completion angio -- angiogram?

A. Well, it's just an x-ray after you've done the procedure to see if the procedure is performed.

Q. To see if there's any complications that may have occurred?

A. That could be one reason.

Q. So that the patient isn't sent from the operating room with complications that should and can, in fact, be corrected while the patient is still under -- still in the operating suite?

A. Well, they're not usually in the operating room suite. They're usually in the radiology suite, but -- so, to that extent, no.

Q. But before the patient is -- is sent back to a general floor?

A. Depending on the degree of complication.

Q. And if there's a rupture of the arterial wall, dye will be shown on that x-ray as being outside of the confines of the artery or vessel?

A. Very often.

Q. Doctor, I'm handing you what I've marked as Exhibit 2A for purposes of your deposition. It is a radiology report re -- pertaining to the completion films after the balloon angioplasty performed by Dr. Sawkar; is that true?

A. I believe so, yes.

Q. You've seen that before?

A. Yes, I have.

Q. Could you read for the ladies and gentlemen of the jury what the radiologist

interpreted the completion film that Dr. Sawkar obtained at the conclusion of his procedure?

A Just read this?

Q Yes Please read the findings

A 'Views were obtained following angioplasty Views of the distal superficial femoral artery show rupture of the superficial femoral artery with a large amount of contrast material extending adjacent to the artery a distance of approximately 7 C So -- Some subintimal contrast material is also seen as well as the frankly extravasated contrast Views of the lower popliteal artery show a small intimal flap '

Q Doctor, you yourself have reviewed the same film that is reported by that radiology report?

A Y s

Q A s you yourself observed contrast material outside consistent with a rupture of the artery?

A. Yes

Q. You are aware, of course, that Dr. Sawkar did not see that same thing that you and the radiologist saw?

A. Correct.

Q And, in fact --

A. At that time, during the procedure.

Q. In fact, you can -- Do you recall from Dr. Sawkar's deposition that even as of this time, Dr. Sawkar still cannot see what you see and what the radiologist sees on that -- on those films?

A. Well, I -- I can't really speak for Dr. Sawkar.

Q. Doctor, can we agree that many patients who have atherosclerotic disease in their lower extremities significant to cause symptoms are older or geriatric patients?

A. Yes.

Q. Can we also agree that these same patients can and often do have other disease processes such as degenerative arthritis, which can itself cause pain and limitations in walking?

A. Correct.

Q. And would you agree that it is essential to confirm that a patient's, symptoms are, indeed, being caused by peripheral vascular disease as opposed to some other condition before recommending that that patient undergo an invasive procedure, such as a balloon angioplasty or a bypass grafting?

A. Yes.

Q. And that is, in fact, why the standard of

care calls for some type of additional testing to be done before surgery is performed or an angioplasty procedure is performed?

MR BONEZZI: Objection. Go ahead and answer

A. I'm sorry Additional testing to what?

Q Mo determine the status of the peripheral vascular disease

A Well, additional testing implies --

Q PVR?

A I'm sorry?

Q. Any kind of PVR, Doppler studies, testing in addition to a history and a physical examination.

A. Ah In addition to a history and physical, yes.

Q And one way to avoid a misdiagnosis and accurately gauge the extent and severity of peripheral vascular disease is to perform noninvasive arterial testing, such as we did -- that you discussed earlier about the Ankle/Brachial Index?

A Yes.

Q Do you agree with this statement? 'Every patient with pain at rest and decreased pulses is

not a candidate for angiography and an art -- and an arterial bypass. Some of these patients will be relieved by appropriate treatment for gout or osteoarthritis."

A. Only if that's their underlying problem.

Q. All right. Dr. Sawkar sent Mrs. Paino to a laboratory for PVR testing on January 30th, 1995; is that true?

A. As the statements that I reviewed, yes.

Q. And that result -- the results of that testing was interpreted by Dr. Sawkar in the report that you read earlier in response to Mr. Bonezzi's questions?

A. Yes.

Q. And that report that Dr. Sawkar dictated actually demonstrates that Mrs. Paino's occlusive disease was worse on her right side, in her right leg, than it was on the left, doesn't it?

A. "Worse" meaning what?

Q. Meaning a worse Ankle/Brachial Index, a decreased value on the right side as opposed to the left.

A. Yes, but it doesn't mean it's worse disease. It means the numbers were -- were indicating a worse disease.

Q. It would be consistent with greater symptoms on the right side than on the left side?

A. No. That's my point.

Q. What were the -- What was the resting Ankle/Brachial Index on the left?

A. .70.

Q. What was it on the right?

A. .55.

Q. .90 is normal; correct?

A. Usually.

MR. BONEZZI: Objection.

A. Usually. 1 is really normal.

Q. I thought you testified earlier that .9 can be normal.

A. It can be, yes, .9.

Q. .7 is not consistent with rest pain, is it?

A. Usually not.

Q. You begin having rest pain at about .25?

A. Depends on the individual, but that's a -- that's a guideline.

Q. You are aware, of course, that Dr. Sawkar diagnosed Mrs. Paino as having rest pain on the left side?

A. He called it night pain, I believe.

Q. Do you believe that he diagnosed it as being consistent with rest pain?

A. I think he diagnosed it as being consistent with significant arterial disease.

Q. Did not Dr. Sawkar recommend that Mrs. Paino have an invasive procedure on the left-hand side because he was convinced in his own mind that she was having rest pain in her left lower leg?

No.

You are aware, Doctor, that Dr. Sawkar now claims that in making his decision to perform an angioplasty procedure on Mrs. Paino's left leg, that when he did the vascular lab study, that the .55 which she reported as being on the -- on the right, he really meant that that was on the left and that the .7 that he reported as being on the left was really representative of the right side? You're aware of that?

A. I believe he testified to that.

Q. And since your deposition and since Dr. Sawkar's testimony, you have been provided with the actual lab worksheet that was generated at the time of the lab study?

A. Yes.

Q. And that lab worksheet, in fact, demonstrates that the left side was, as in -- as tested, .7, and the right side was .55?

A. Yes.

Q. Inconsistent with **Dr.** Sawkar's contention that he transposed the numbers or values?

A. Well, I mean, he still wrote this. I mean, if that's his testimony, he transposed it, he transposed it. I mean, he -- this is his report, so, I mean, **I** -- I have no opinion as to whether or not it's an error or anything else.

Q. Doesn't the vascular lab worksheet that you've been provided since your deposition and since Dr. Sawkar's dep -- deposition establish that, in fact, the left side is .7 and not .55 as Dr. Sawkar contended in his deposition testimony?

A. It doesn't establish anything more than what's written on it. I mean, whether or not it was transposed or not, I have no way of knowing.

Q. Doctor, you testified earlier that -- that Mrs. Paino has significant or severe degenerative arthritis in her left knee.

A. I believe that's correct.

Q. **You** did not know that a month ago when your deposition was taken?

A. I -- Unfortunately, I forgot about it. I reviewed the records and found it in there.

Q. What do you know about what Mrs. Paino says about her symptoms as to whether or not she was having pain in her calf or whether she was having pain in her knee consistent with degenerative arthritis when she saw Dr. Sawkar in January 1995?

A. I know no more than the records I've reviewed.

Q. You have not heard anything from Mr. Bonezzi as to what Mrs. Paino says about that other than what is in Dr. Sawkar's records?

A. No, I haven't.

Q. Doctor, is a Brachial -- is a Brachial/Ank --

A. Ankle/Brachial.

Q. -- Ankle/Brachial Index consistent with a .7 consistent with intermittent claudication?

A. Absolutely.

Q. And do 80 patient -- 80 percent of patients with intermittent claudication improve or remain stable without vascular intervention of invasive nature?

A. 80 percent? I --

Q. Yes.

A I don't know if that's the number. I mean, it depends on whose practice you're in.

Q Well, if you don't agree with the fact that it's 80 percent, can we agree that it's the majority of patients with intermittent claudication will improve or remain stable without any kind of invasive procedure?

A There are too many variables for me to agree to that statement

Q Have you seen such statements published in the medical literature by highly regarded vascular surgeons in this country?

MR DONEZZI: Objection to the form of the question.

A. No

MR. DONEZZI: Go ahead and answer.

A I'm not aware of anybody saying that, making a statement just carte blanche like that

Q Are you familiar with a vascular surgeon by the name of Richard Kamazinski®

A Yes Poor Richard

Q What is -- what was his status as a vascular surgeon in this country?

A He was the chairman of the Department of Surgery at the University of Cincinnati

approximately until his tragic, tragic accident two and a half years ago.

Q. Highly regarded in his field?

A. Again, I don't know what you mean by "highly regarded." He was the chairman of the department.

Q. Regularly published in the medical literature?

A. Yes.

Q. Do you know a Dr. Richard Fowl?

A. Fowl?

Q. F-o-w-l, also from the University of Cincinnati.

A. No.

Q. Are you aware if Dr. Kampzinski and Dr. Fowl published materials on the issue of intermittent claudication that would indicate that a greater majority of patients with intermittent claudication are not candidates for any kind of invasive procedure and that their claudication will remain stable and, in many instances, improve without any further treatment?

MR. BONEZZI: Objection.

A. Actually, the only study I'm familiar with of Dr. Kampzinski's, which was very highly

publicized, was his carotid endarterectomy study where he said that 10 to 15 percent of people having endarterectomy in the community setting will have a stroke. That proved to be grossly, grossly wrong.

So to answer your question, the only studies I'm familiar with in the literature of Dr. Kampzinski's are disproven.

Q. Let's talk about the first surgery after the rupture of the artery and Mrs. Paino was taken back to the operating -- or taken to the operating room by Dr. Sawkar. You've seen that operative report, Doctor?

A. The bypass procedure?

Q. Correct.

A. Yes, I have.

Q. This was an emergency procedure?

A. Yes.

Q. And that was done within an hour of her losing her pulses in her left leg after the angioplasty?

A. Somewhere in that time frame.

Q. And this was an emergency procedure because with blood flow interrupted, it was determined that her left leg would be threatened if blood flow was not promptly reestablished?

A. That's a safe statement.

Q. And do you agree with Dr. Siebert that time is of the essence under these circumstances to get the flow of blood reestablished?

A. No. Time's important. I wouldn't say it's of the essence.

Q. What do you mean by time's important?

A. You have a window of opportunity to -- you know, you don't have to do it within an hour or two hours. Usually, the revascularization in a situation like this should take place within five to seven hours.

Q. So within five to seven hours, it is the goal of the vascular surgeon to have the flow of blood reestablished to the lower leg so that permanent nerve damage or tissue death does not occur from ischemia and resulting complications?

A. Well, I -- I wouldn't exactly put it that way, no.

Q. So we'll just leave it at the fact that it should be done within five to seven hours?

A. In this acute situation, that's the optimal, yes.

Q. And Dr. Sawkar determined that during the exploration of the left leg, that a bypass of the

blockage would be necessary?

A. Correct.

Q. And he harvested the left saphenous vein in an effort *to* use it for the bypass procedure; correct?

A. I -- I believe he harvested it or evaluated it in some way.

Q. And he found it to be clottic -- clotted and phlebitic; true?

A. Correct.

Q. Not a surprise in view of the fact that in 1993 Mrs. Paino was treated for severe thrombophlebitis in her left leg and was, in fact, hospitalized for that problem?

A. Left or right, yes.

Q. Left?

A. Yeah. Yes.

Q. She was treated for her left leg DVTs in 1993; correct?

A. She was treated for both leg DVTs, according to his medical records.

Q. All right. Let's explore that a little bit.

A. Okay.

Q. Where in the medical records are you

referring to her receiving treatment in -- for her right leg?

A. His office chart.

Q. And what is it in his office chart that leads you to conclude that she received any form of treatment because of significant disease in her right leg?

A. His office note.

Q. And what does his office note say about that?

A. I can't recall verbatim, if you'd like to show that to me.

Q. I certainly will. In fact, Doctor, perhaps you can read the May 20th, 1993, office note to which I think you're referring. And I have, in fact, typed out verbatim above Dr. Sawkar's charting perhaps to make it easier for you. What did Dr. Sawkar say about Mrs. Paino's condition on that date?

A. On May 20th, 1993, "Left leg severe varicose vein with superficial phlebitis. Right - mild. Plan: Continue Indocin. Return to office," or RTC is what it -- RTO is what it says. You write, "Return to office three weeks. Possible surgery," the symbol for left leg.

Q. All right. Now, Doctor, is that the record to which you're referring to in -- when you say that Mrs. Paino received treatment for right leg thrombophlebitis?

A. For both, yes, is what I said.

Q. All right. And do you find any reference anywhere else in Dr. Sawkar's records or any other records to suggest that Mrs. Paino had any difficulty or treatment with regard to her right leg?

A. Right saphenous vein?

Q. Yes.

A. No.

Q. Doctor, isn't it the fact that Dr. Sawkar is referring to mild varicosities in May 20th, 1993?

A. It just says "mild." I don't know if they're varicosities or the greater saphenous. I would assume it's the greater saphenous.

Q. Doctor, I'm handing you what I've marked as Exhibit 2C. Can you tell us what that is?

A. It says -- dated 6/21/93, a Non-invasive Vascular Lab Duplex Scan Lower Extremity - Venous Worksheet.

Q. And what leg was that for?

A. The left.

Q. Any mention of anything about the right?
A. If I can review this a moment.
Q. Certainly.
A. (Reviewing document.) Okay. No. The report seems to only discuss the left side.
Q. All right. Handing you what I've marked as Exhibit 2D, can you tell us whether or not that relates to also problems with Mrs. Paino's left leg?
A. This is a Venous Duplex done on the same date, 6/21/93, and it speaks to the left side.
Q. Exhibit **2E**, Doctor, can you tell us what that is?
A. It's a requisition for the studies that we just spoke to.
Q. And what does it talk about as far as --
A. Well., the same, that --
Q. Left leg?
A. Yeah. I mean, this is what led to the others that you showed me. They're all, basically, the same document.
Q. Says rule out DVT left leg?
A. Correct.
Q. Doesn't say rule out DVT right and left leg?
A. No.

Q. You're aware that Mrs. Paino was hospitalized in 1993 for treatment of her left leg thrombophlebitis?

A. Well, I think it was for a DVT extending to the femoral vein, so --

Q. All right.

A. -- yes, but not for the superficial phlebitis.

Q. All right. Doctor, have you seen the hospital record relating to that hospitalization?

A. I think I did.

Q. I've marked it as Exhibit 2F for purposes of your deposition. And to simplify matters --

A. Uh-huh.

Q. -- I have counted and highlighted in that charting 11 separate references to Mrs. Paino's left leg and submit to you that there is not a single reference in that entire hospital chart to any treatment, any complaints, or any problems with her right leg. And if you want to -- to refresh your memory or to review that, please do.

A. No. I -- I have no reason to dispute that,

Q. Doctor, can you -- I'm handing you the operative report that we've been talking about,

Exhibit 2B, the operative report dictated by Dr. Sawkar relating to the harvesting or the attempt to harvest the left saphenous vein and the ultimate decision to use a Gore-Tex graft to perform the bypass procedure. And I've taken the liberty of highlighting so that you can go right to it.

At the bottom, Dr. Sawkar stated thought process as to why he was going to use Gore-Tex as opposed to either using the left saphenous vein or the right saphenous vein, as he testified would have been his preference.

Would you read for the ladies and gentlemen of the jury, Doctor, what Dr. Sawkar wrote or dictated following this procedure as to his rationale?

A. You want me to read your highlighted areas?

Q. Yes, please.

A. "Meanwhile why" -- "Meanwhile we harvested the saphenous vein and we were trying to inside to bypass, but when we opened the vein for the proximal anastomosis to the common femoral and superficial femoral junction, we found that the vein had thrombosed and was phlebitic and there was no real good lumen noted. Hence we decided not to use

saphenous vein as this was thrombophlebitic and moderate degree of varicosities were noted and no true lumen was identified. In the other leg the patient had superficial thrombophlebitis and deep vein thrombosis. A few months ago it was treated with anticoagulation, saphenous vein is not available in that leg for this purpose. Hence, we had no other choice other than to use 6 and 1/2 to 4 and 5 -- and 1/5 Gore tex graft was used."

Q. That isn't true, is it, Doctor? Dr. Sawkar never treated Mrs. Paino for right-sided thrombophlebitis several months before this procedure?

A. Not in the hospital.

Q. Where -- He didn't treat her anywhere for thrombophlebitis in the right leg several months before this procedure because he'd only seen her on January 30th, 1995, and not since 1993; true?

A. 19 -- 1993 is when he saw her. Is that what you're asking?

Q. No. I'm asking you -- Dr. Sawkar dictated in his record that the reason that he didn't harvest the right saphenous vein is because several months before this, he was treating her right leg for deep vein thrombosis. What I'm asking

you, Doctor, is: That is not true, is it?

A. I'm not aware that he was, no.

Q. A few months before, Mrs. Paino wasn't even his patient; true?

A. Well, she was his patient in '93.

Q. She hadn't seen him since 1993 until January of 1995; true?

A. I have no records that he had.

Q. Isn't it true, Doctor, that Dr. Sawkar made an intraoperative error in mistaking which leg he had treated in the past for deep vein thrombosis and concluded in his own mind that he had treated the right, and that's why he didn't harvest the right saphenous vein to do the bypass procedure?

A. I'm not going to presume to read his mind.

Q. And the reason that Dr. Sawkar wanted to use the saphenous vein instead of a prosthetic or Gore-Tex graft is because there's a better patency rate with the saphenous vein as opposed to a prosthetic graft; true?

A. Long-term patency, yes,

Q. And that is something that Dr. Sawkar recognized in -- in accordance with his testimony?

A. Yes.

Q. And that is consistent with what is reported in the literature, is it not?

A. That -- That what?

Q. Long-term patency of a saphenous vein or an autologous graft is better than a prosthetic or Gore-Tex graft?

A. Yes. Long-term patency is.

Q. What did Dr. Droubi use when he revascularized Mrs. Paino on March lst, 1995?

A. He used her right greater saphenous vein.

Q. The one that Dr. Sawkar concluded was not viable?

A. Yes.

Q. You are aware, Doctor, that Dr. -- that Mrs. Paino s Gore-Tex graft showed signs of shutting down at around midnight on February 27th?

A. Perhaps.

Q. That's what you testified to at your deposition a month ago, didn't -- isn't it?

A. Yeah. I said somewhere around 1:00, midnight, something of that nature.

Q. Well, in fact, at Page 38 of your transcript, if you'd care to look at it, you said midnight, didn't you?

A. If you say so, that's fine.

Q. And that was about an hour after the surgery, hour and ten minutes after the procedure?

A. Yes.

Q. And you are also aware, Doctor, are you not, that Dr. Sawkar testified that he was not informed by his resident, Dr. Siebert, that Mrs. Paino's left leg was becoming progressively more ischemic through that night?

A. Yes.

Q. And you're aware that Dr. Sawkar testified that had he been notified of that fact, he would have taken her back to the operating room for another procedure?

A. I -- I believe that's correct.

Q. And you're aware, of course, that Dr. Siebert testified that he did -- did keep Dr. Sawkar informed of her condition on that night; correct?

MR. BONEZZI: Objection. Go ahead and answer.

A. I don't recall his wording. I think you asked him a question and he answered in the affirmative; in other words, "Did **you** notify him?" and he said, "Yes."

Q. Handing you what I've marked as

Exhibit 2G is Dr. Siebert's progress note on 2/28. Is that 1:50 a.m.?

A. Correct.

Q. And do you see that Dr. Siebert wrote in that notation "D/W staff"?

A. Right.

Q. And what do you suppose that entry refers to when he wrote "D/W staff"?

A. Discuss with staff.

Q. Is it your belief and is it your opinion in this case that Dr. Siebert, in fact, did keep Dr. Sawkar informed of Mrs. Paino's deterioration in her left leg and the indications of a graft shutdown at 1:50 a.m. or thereabouts as con -- as is consistent with that record?

MR. HEALY: Objection.

A. I -- I don't know what "staff" refers to, so I -- I can't answer that. Could have been somebody covering for Dr. Sawkar, for all I know.

Q. Well, if we -- if we refer to Dr. Siebert's deposition, we will see that what Dr. Siebert referred to was discussing with Dr. Sawkar; is that not true?

A. That's his testimony, yes.

Q. And Dr. Sawkar denies that; correct?

A. I believe that's correct

Q. So you agree with Dr. Siebert that early recognition of graft thrombosis is extremely important in a patient like Mrs Paine?

A. In this particular situation?

Q. Yes.

A. It's important, yes. I don't know about it's extremely important

Q. That's so blood flow can be re- restored to avoid permanent damage?

A. Very often that's the case. Sometimes you don't.

Q. Doctor, do you agree with this statement? 'If thrombosis is recognized early at a stage of reversible ischemia and without a substantial change in the patient's general condition, immediate reoperation with thrombectomy, intraoperative intra-arterial infusion of thrombolytic agents, intraoperative arteriography and correction of any technical errors must be considered the accepted means of management

Exceptions to this policy require justification. The decision not to operate could be justified if the patient has suffered an acute myocardial infarction or some other life-threatening

complication after the original operation, forcing the surgeon to observe the priority of life over limb."

MR. BONEZZI: Objection.

Q. Do you agree with that statement?

MR. BONEZZI: Objection.

A. In its entirety?

Q. Yes.

A. No.

Q. Do you agree with this statement? "Early recognition of graft thrombosis is ex -- is extremely important. Even if graft thrombosis does not immediately threaten limb viability, the success of management decreases as the time between graft thrombosis and treatment increases."

MR. BONEZZI: Objection.

Q. Do you agree with that statement?

A. No.

Q. Do you agree with this statement? "Occlusion within one week of operation and particularly within two to three days is generally attributed to technical error or to poor patient se1ection."

MR. BONEZZI: Objection.

A. Partially.

Q. What part do you agree with?
A. That occlusion very early is very often secondary technical error.
Q. You're aware that Mrs. Paino has no ability to use her foot now?
A. I -- I'm not sure what you mean, "use her foot."
Q. Well, can she -- can she move her foot?
A. I don't know. I think she -- she's walking with a walker. I don't know what her foot's doing.
Q. Has Mr. Bonezzi indicated to you what Dr. Wilborne testified to, his nerve conduction and EMG testing demonstrated with regard to the extent of the nerve damage to her left lower extremity?
A. No.
Q. What is paresthesia?
A. It's a tingling feeling.
Q. Is that an important finding when one is trying to assess the viability of a leg following a graft occlusion?
A. No.
Q. What is important to determine whether or not revascularization is necessary after a graft occlusion is suspected?

A. I think you have to take into consideration a host of factors, the condition of the extremity itself, the condition of the patient, the amount of surgery that needs to be done to reestablish flow, whether or not that operation is -- is warranted, what the chance of successes are versus the risks. Just a whole -- a whole host of factors need to be considered. Sometimes primary amputation should be entertained instead of revascularization in this situation.

Q. You testified earlier, Doctor, that, in your opinion, Dr. Sawkar should have taken her back to surgery.

A. Yes.

Q. That's a new opinion, isn't it?

A. No.

Q. You never testified to that at the time of your deposition, did you?

A. I was never asked that.

Q. Did you express it in your report that you gave to Mr. Bonezzi?

A. No.

Q. You testified that, in your opinion, had Dr. Sawkar taken Mrs. Paino back to surgery the next morning, that --

A. This is -- I'm sorry -- which morning, now?

Q. The -- The morning of the 28th --

A. Okay.

Q. -- the follow -- the morning, very -- very next morning after her graft occluded.

A. Uh-huh.

Q. Your testimony was that if Dr. Sawkar had taken her back, you don't -- you believe that she would have already suffered permanent nerve damage?

A. That's correct. I don't think that the results Dr. Droubi obtained would have been any different had Dr. Sawkar or Droubi done it a day earlier.

Q. Handing you progress note of February 28th, Doctor, which I've marked as Exhibit 2H, is it?

A. Correct.

Q. What does the bottom progress note indicate as to what time of morning it was that Mrs. Paino was observed still being able to move her left foot?

A. The highlighted area?

Q. Yes.

A. 11:00 a.m. or 11:00. 11:00. I assume

it's 11:00 a.m.

Q. So even as of the morning of the 28th at 11:00 a.m., some physician observed that Mrs. Paino was still able to move her left foot; correct?

A. I don't know if that's a physician. Can you read who that is?

Q. So -- So -- Would it be fair to say that only a physician would be writing in the progress notes?

A. No. Nurses write the progress notes. Vascular technicians write in the progress notes. Respiratory therapists write -- I -- I don't know who this is.

Q. Well, I don't either, but we can assume that: it's a medical care practitioner providing some sort of medical care to Mrs. Paino; true?

A. Yeah. A medical care technician, perhaps, right.

Q. And she was able to move her foot at 11:00 a.m. on the 28th, the very next morning; correct?

A. "Able to move foot," is the statement written.

Q. And had that changed since that time, to your knowledge?

A. I don't know.

Q. Isn't the reality, Doctor, from looking at the records, that Dr. Sawkar simply gave up on this patient because he concluded that she did not have any kind of horseback vein, and he had done a Gore-Tex graft procedure, and there was nothing more that he thought he could do?

MR BONEZZI: Objection.

A No. I -- That's not the reality The reality is -- is that he was going to bring in a vein from Atlanta from a cadaver.

Q. Where is that -- I'm sorry I don't mean to interrupt.

A That -- That was in his deposition and his testimony, that he discussed this with the family.

Q. When looking at the records, and I mean the records consisting of the entire hospital chart, Dr. Sawker's entire office records, do you find any reference to any kind of plan demonstrated in the records that Dr. Sawkar made any kind of recommendation or considered harvest -- obtaining a cadaver vein from anywhere to perform an additional procedure on Mrs. Paino?

A. Well, I wouldn't expect it in his office

records, but, no, I don't see it in the hospital record.

Q. You are aware, of course, that Dr. Sawkar testified that he denies scheduling Mrs. Paino for an amputation?

A. I believe that's correct.

Q. In fact, you know that's not true, do you not?

A. Well, I know that he had her sign an amputation consent form.

Q. Well, do you know if he had her actually scheduled for the procedure?

A. I don't recall.

Q. Okay. Handing you what I've marked as Exhibit 21 is a preoperative nursing record. Can you tell us what that preoperative nursing record indicates is being contemplated for Mrs. Paino?

A. It says, "Operative Procedure - Left AKA," above-the-knee amputation.

Q. Doctor, handing you what I've marked Exhibit 2J, can you identify what that document is?

A. Oh, okay. This is the operating room schedule of Fairview General Hospital for March the 1st --

Q. Can you flip --

A. -- Wednesday.

Q. Can you flip on Page 2 and tell us, from the operating room schedule at Fairview General Hospital, what is shown as far as it relates to Dr. Sawkar and Mrs. Paino for March lst?

A. There's something written on here. I don't know whose handwriting it is. It's not typed in like most of the stuff on this schedule is. And it says, "TF," which means to follow, "Sawkar, Paino, Linda, #2, 76." That's her age. Under anesthesia is "AC," and it says left AK amputation.

Q. Doctor, in your efforts to assist Dr. Sawkar in this case, is it your belief that that is not a legitimate entry made in the normal course of events in filling out that operating room log at Fairview General Hospital?

A. In my efforts to assist Dr. Sawkar? My efforts are, basically, to testify as an expert in this case.

Q. Well, why is it that you make a -- an effort to indicate that that does not appear to be consistent with other entries on that record?

A. Because it's -- I didn't make an effort to say it's inconsistent. I said that this was written in separately. The operative report --

The -- The surgical schedule is a typed schedule that you handed me This is a handwritten entry

Q. All right.

A That's all I said

Q Are there not at least seven other handwritten entries for other patients for that same date?

A I see two I see several others, yes

Q Handing you what I've marked as Ex -- Exhibit ZK, can you tell us what that progress note indicates in the hospital record?

A It says, '3-1-95, 5 -- 0530,' so it's 5:30 in the morning, and it says, 'Ischemic left lower extremity scheduled for AKA today ' And it gives some -- somebody's name with, I believe, an M D afterwards.

Q. Is it fair to say that the records would seem to be totally inconsistent with Dr Sawyer's sworn testimony that he did not schedule Linda Paino for an amputation?

A. No. I -- It just says that she's for an amputation. I don't know who scheduled it or -- or, you know, what the plan was, but I don't think it's inconsistent We mentioned amputation to the Paino family

Q. Doesn't he -- Doesn't she now say that what she did was he mentioned that that was a -- a risk of an angioplasty procedure?

A Oh, I don't -- No, no, no I'm talking a out afterward

Q Okay Doctor, handing you Exhibit 2L, which is Dr Droubi's discharge sum ry, can you read for the ladies and gentlemen of the jury what Dr Droubi has to say about the circumstances surrounding his reason to become involved in this case --

MR DONEZZI: Objection.

Q. -- or in Mrs. Paino's treatment?

MR DONEZZI: Objection.

A. His note -- Dr. Droubi's note says, "I was called to evaluate the patient on 03/01/95 t 3:30 p m because the patient refused the decision of Dr. Sawkar to perform above knee amputation. The family called me in as a second opinion for attempt at revascularization."

Q. How long did Mrs. Paino lay in the hospital with no circulation to her left leg below the knee following her graft shutdown at about midnight before she was finally taken for an effort at rewascularization?

MR. BONEZZI: Objection as to the time Go ahead

A. Well, I -- I don't think she ever lay in the hospital with no circulation to her legs She had circulation, just not very good circulation.

Q With significantly compromised circulation so as to cause ultimate permanent nerve and muscle damage, how long did she lay there; how many hours did she lay there in that condition?

A She had that condition develop immediately after the angioplasty, so whatever the time frame is From the angioplasty time on to present time.

Q. Well, didn't she have good pulses after the Gore-Tex graft procedure? didn't she return -- Wasn't she returned to the hospital recovery room having circulation to her lower extremity following the Gore-Tex graft procedure?

A According to the notes, yes

Q So from the time that that Gore-Tex graft shut down, whether it's 12:00 midnight or 1:00 a m., how long did she lay in the hospital with inadequate circulation to her left lower leg?

A Well, if -- if you're using that as a time frame for inadequate circulation, then it was

whatever the hours were, 24 hours, 36 hours.

Q. Doctor, do you have a curriculum vitae handy indicating what your qualifications are and what -- your experiences in vascular surgery?

A. My qualifications?

Q. Do you have it written down as Dr. Sawkar had his written down on Exhibit 1? Do you have such a document handy?

A. I have a CV, yes. I don't -- I can get it for you, if you wish.

Q. All right. Could we -- At the conclusion of the deposition, can we mark it as an exhibit so that we don't take the time now?

A. Are you asking me if you can? Of course you can.

Q. I'm asking if you can just get one --

A. Oh, oh, of course.

Q. -- and we'll mark it as an exhibit.

A. Sure.

Q. Thank you. You do not do any teaching in vascular surgery?

A. Not presently. I did in Cleveland for many years.

Q. That's when you trained some residents at the VA Hospital?

A. Well, that's when I was the Assistant Clinical Professor at the VA -- at Case Western Reserve University, yes.

Q. That means that you -- you have residents who you assist and train?

A. At the VA as well as at Mount Sinai, yes.

Q. Okay. You have worked with Mr. Bonezzi as an expert witness in the past, have you?

A. Once or twice, yes.

Q. In fact, about 75 percent of your defense work as an expert witness is for Mr. Bonezzi's firm, Jacobson, Maynard & Kalur -- or & Tuschman?

A. That's about correct.

Q. You play golf with Mr. Bonezzi?

A. I have twice in my life.

Q. His partner, Pat Murphy?

A. I have. He was a neighbor of mine. That's the capacity that I knew Pat.

Q. Saw him socially?

A. I'm sorry?

Q. Saw him socially?

A. Our families lived on the same street, and we would have block parties and things like that together.

Q. In fact, you've been represented some

five times by Mr. Bonezzi's law firm, Jacobson, Maynard & Tuschman; is that true?

A. Represented?

Q. Yes. As -- They were your attorneys?

A. In what situations, please?

Q. In lawsuits where you were named as a party and they were representing you.

A. I -- I really don't -- you know, I've never really been settled or sued or anything like that. I mean, if that's what you're representing.

Q. Well, I'm representing to you, Doctor, and I'm only asking you whether or not you have been represented on five separate occasions by the Jacobson, Maynard, Tuschman law firm in your professional capacity as a physician.

A. I -- I don't know the answer to that. If you want to give me the instances and count them up, that's fine.

Q. Well, I -- I don't want -- I don't want to make it look like I'm being unfair to you, and -- and I'm not trying *to* do anything other than to establish that they have represented you on five separate occasions.

MR. BONEZZI: We'll stipulate that we -- the law firm has, in fact, in the **past** represented

Dr. Pitluk.

Q. And do you doubt that it's five times, Doctor?

A. I don't doubt anything in that respect.

Q. Okay.

A. I don't know what the implications are, but --

Q. There are no implications, Doctor.

A. Oh, okay.

MR. HAWAL: Thank you. I have nothing further.

THE WITNESS: Thank you.

MR. HEALY: I have no questions.

EXAMINATION

BY MR. BONEZZI:

Q. Dr. Pitluk, I have a couple of them for you.

A. Sure.

Q. The first question that I have is this: Do you believe that any association that you have had with either me or my law firm in the past or any associations that you may have had with a partner of mine, who happened to be one of your neighbors, would cause you to provide testimony in such a way

that would be considered untruthful?

A. Mr. Bonezzi, I -- I'm under oath, and under no circumstances would any relationship I have with anybody, either adversarial or otherwise, would I ever allow that to interfere with my testimony.

Q. Isn't it a fact, Dr. Pitluk, that on occasion you and I have met where you have been a witness against me?

A. Yes, it is.

Q. Very briefly, when tests are conducted pertaining to determining whether or not there is any type of abnormality with the vessels of the lower extremity, is there always a consistent pattern with the numbers that you receive, for instance, from an ABI and the complaints from a patient?

A. No.

Q. And, as a matter of fact, in this case, as Mr. Hawal pointed out, there may not have been any specific complaints relative to the confinement in 1993 regarding the right leg, but there was, indeed, information obtained relative to that same right leg when tests were conducted in 1995; is that correct?

MR. HAWAL: Objection to the form of the

question.

A. Yes. That is correct.

Q. I'll ask it a different way, Doctor. To what extent, if at all, do you remove the test results obtained in 1995 from the Ankle/Brachial Index and only accept the lack of complaints relative to the right side as the determining factor of whether there was, indeed, stenosis or occlusion on the right side?

A. In --

Q. 1995.

A. I -- As I said, you -- you have to take the history first and foremost, and that's the most important factor here in conjunction --

Q. And then to what extent do you attempt to correlate the history with the test results?

A. I think that's important to do.

Q. And to what extent, if at all, do you then exercise a patient relative to a PVR study where there is, indeed, no complaints relative to one side or the other, but there is definitive information that suggests otherwise?

A. That's very important to do, as was done.

Q. And do the test results in this case definitively set forth, regardless of complaints,

regardless of history, that there was involvement on the right side in 1995?

A. Yes, it does.

Q. Would you please take a look at Exhibit 2A, which I believe is an exhibit that as provided to you by Mr. Hawal? And it expressly sets forth the radiologist -- I believe that's Dr. Irish's opinion or interpretation. It should be the very first one.

A. 2A?

Q. Uh-huh.

A. Is this 2A?

Q. It's right there.

A. Oh.

Q. Right there in front.

A. It's up here.

Q. Uh-huh.

A. Sorry.

Q. All I want you to do is tell us what date that was transcribed.

A. Transcribed on 03/01/1995.

Q. And was that the same identical day in which the interpretation was made?

A. No.

Q. And can you tell us whether or not the

records indicate any conversation between Dr. Irish providing information to Dr. Sawkar regarding his findings?

A. I'm not aware of any conversation in the records, no

MR BONEZZI: Nothing further. Thank you, sir

EXAMINATION

BY MR HAWAL:

Q Doctor, I have one follow-up, and that is relating to the question that Mr. Bonezzi asked you about studies in 1995 indicating involvement on the right side Are you suggesting that the PWR studies in 1995 on January 30th would indicate that Linda Paino had deep vein thrombosis in her superficial or her saphenous vein in 1995? Is that what you're suggesting?

A No

MR HAWAL: Okay Thank you. I have nothing further.

MR BONEZZI: Thank you, Doctor.

THE WITNESS: Thank you.

(Exhibit 3 marked for identification)

(The deposition was concluded)

HOWARD PITLUK, M.D.

C E R T I F I C A T I O N

* * * * *

BE IT KNOWN that I, Sherri K. Williamson, took the foregoing deposition at the time and place stated in the caption hereto; that I was then and there a Notary Public in and for the State of Arizona; that by virtue thereof I was authorized to administer an oath; that the witness, HOWARD PITLUK, M.D., before testifying was first duly sworn to state the truth; that the testimony of said witness was reduced to writing under my direction; and that the foregoing **104** pages contain a full, true and accurate transcription of my notes of said deposition.

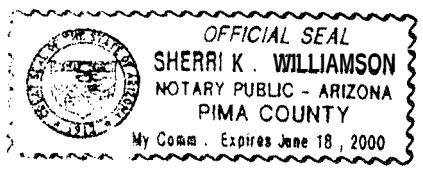
I FURTHER CERTIFY that I am not of counsel nor attorney for either or any of the parties to said cause or otherwise interested in the event thereof; and that I am not related to either or any of the parties to said action.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my seal of office this 12th day of September, 1997.

---------- Sherri K Williamson ----------

NOTARY PUBLIC

My Commission Expires: **6/18/00**



FAIRVIEW GENERAL HOSPITAL **RADIOLOGY INTERPRETATION**

)AINO ,LINDA
:431 COLUMBIA **SQU** **104**
NORTH OLMSTED OH **44070**
:79-5003

MAIDEN **LAURENTI**
BIRTH **07/07/1918** AGE **076** Y
272-10-7881

ROOM 0200 **-15**
DAY **NO.** ***090***
00000404595

SAWKAR RAGHU MD
20997 LORAIN RD
FAIRVIEW PARK **OH** **44126**
)56-0044

CETIN DERRICK C **DO**
24700 LORAIN ROAD **207**
NORTH OLMSTED **OH** **44070**
777-1002

LEFT-ANGIO/EXT-UNILA
CLINICAL: BALLOON ANGIOPLASTY

VIEWS WERE OBTAINED FOLLOWING ANGIOPLASTY. **VIEWS** OF THE DISTAL SUPERFICIAL FEMORAL ARTERY SHOW RUPTURE OF THE SUPERFICIAL **FEMORAL** ARTERY WITH **A** LARGE AMOUNT OF CONTRAST MATERIAL EXTENDING ADJACENT TO THE ARTERY **A** DISTANCE OF APPROXIMATELY **7 CM.** ***SOME*** SUBINTIMAL CONTRAST MATERIAL **IS ALSO SEEN AS** WELL AS THE FRANKLY EXTRAVASATED CONTRAST. **VIEWS** OF THE LOWER POPLITEAL ARTERY SHOW **A SMALL** INTIMAL FLAP.

XXX-XRAY-FLUORO FEE
SEE LEFT ANGIO.

CRAIG R. IRISH, M.D.

EXAMINATION COMPLETED ON 02/27/1995
READ BY CRAIG R. IRISH, M.D. ON 02/28/1995 AT 0220P
TRANSCRIBED BY CC ON 03/01/1995 0124P MAILED ON 03/01/95
****

XRAY REPORT FINAL DOCUMENT

PLAINTIFF'S EXHIBIT 2A
ALL-STATE LEGAL SUPPLY CO.

PATIENT:	PAINO, LINDA
MR NO.:	272-10-7881
DATE OF PROC.:	02/28/95
ROOM NO. :	200-5
HOSP. SVC.:	SEM

HEALTH CLEVELAND
PROVIDING A CIRCLE OF CARE

FAIRVIEW GENERAL HOSPITAL
Cleveland, Ohio 44111-5659

PLAINTIFF'S EXHIBIT 2B
ALL-STATE LEGAL SUPPLY CO.

PREOPERATIVE DIAGNOSIS:

POSTOPERATIVE DIAGNOSIS:

OPERATION:

SURGEON: R. Sawkar, M.D.

ASSISTANTS: P. Siebert, M.D.

ANESTHESIA: Spinal.

This patient underwent balloon angioplasty a couple of hours ago. She had a strong pulse, gradually pulse diminished and almost disappeared. The patient is having numbness in the foot. I was notified from the recovery room and hence we decided to take the patient back for exploration. The problem was discussed with the patient and her family including that she may need thrombectomy and fempop bypass as well as peroneal bypass, if we cannot salvage the artery and re-ballooning was considered also. The risks of the procedure, inability to revascularize leading on to amputation was briefly mentioned. The patient was taken to surgery.

PROCEDURE: After adequate prep and draping, under spinal anesthesia, the left groin was explored and it was found that the proximal femoral artery was opened with intraoperative arteriography. (Please note, the surgeon was Dr. Sawkar assistant to Dr. Siebert). Upon doing an arteriography, found that superficial femoral in the mid thigh was totally occluded. There was no flow below that noted. We tried to pass a Fogarty catheter after heparinizing the patient. We got a moderate amount of clot. Fogarty would not pass beyond the middle of the thigh. Hence, we decided to explore the popliteal artery. First we explored the popliteal artery above the knee, found the artery was extremely diseased. No true lumen was available here to do any distal anastomosis. Below the knee popliteal artery was explored, even here it was completely collapsed with no true lumen noted even in this area with thrombus seen, which was removed. We could not get any soft spot to put a graft here. Then we extended the incision to the tibial peroneal trunk area beyond the trifurcation, found what looked like a reasonable soft artery at this level and gentle fogarty was introduced distally. A small amount of clot was removed. Very little backflow was obtained. Meanwhile we harvested the saphenous vein and we were trying to inside to bypass, but when we opened the vein for the proximal anastomosis to the common femoral and superficial junction, we found that the vein had thrombosed and was phlebitic and there was no real good lumen noted. Hence we decided not to use saphenous vein as this was thrombophlebitic and moderate degree of varicosities were noted and no true lumen was identified. In the other leg the patient had superficial thrombophlebitis and deep vein thrombosis. A few months ago it was treated with anticoagulation, saphenous vein is not available

HEALTH CLEVELAND
PROVIDING A CIRCLE OF CARE
FAIRVIEW GENERAL HOSPITAL
Cleveland, Ohio 44111-5659

in that leg for this purpose. Hence, we had no other choice other than to use 6 and 1/2 to 4 and 1/5 Gore tex graft was used. First it was anastomosed to the superficial and common femoral junction with running 6–0 Gore tex suture. After watertight closure, inflow was obtained to the graft, which was pretty good. After that it was tunneled through anatomic tunnel and brought in the tibial peroneal trunk area and it was anastomosed end–to–side with 6–0 Prolene suture as the tibial peroneal trunk anastomosis was carried out. Heparin was instilled distally. We encountered a moderate amount of bleeding. All bleeding was controlled and completion angio. showed patency of the anastomosis, however, distal flow was somewhat poor because the quality of the artery, peroneal, was not good, thickened lumen was very small, runoff was of poor quality. However, at the end of the procedure the patient had weakly dopplerable posterior tibial pulse, was not very happy with the quality of this artery as well as how she thrombosed the whole arterial system from the mid thigh to the trifurcation, including the tibial peroneal trunk. Prognosis is poor as limb salvage may not be possible because of her poor outflow as well als non–availability of the saphenous vein and extremely diseased femoral popliteal and tibial arterial system. This was discussed with the patient's daughter and also the patient was notified in the Intensive care unit. If the graft does not stay open, the patient probably will loose the limb. The patient has severe arthritis in the left knee, BK amputation is not feasible because of the arthritis, may not be a candidate for prosthesis. So most probably ahe will need an AK amputation if the graft does not support the circulation to the leg. This was notified to the patient's two daughters as well as the patient.

Dictated by: R. Sawkar, M.D./ff
D: 02/28/95
T: 02/28/95

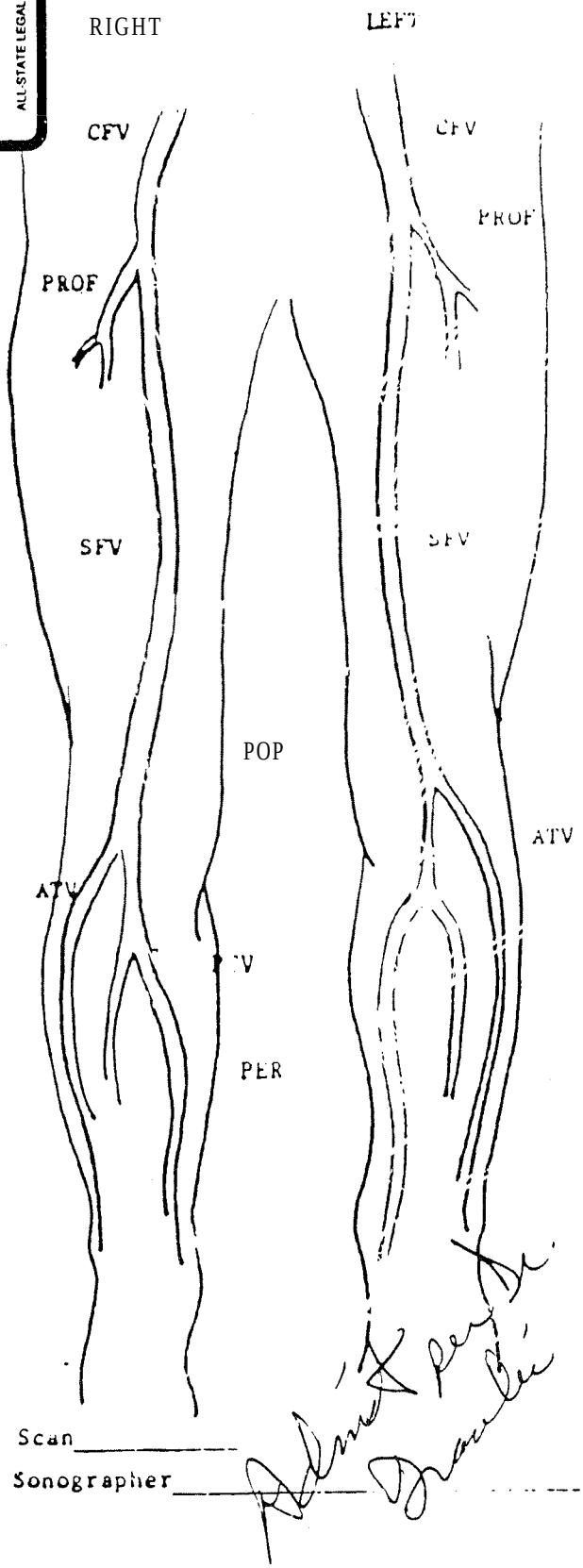
PLAINTIFF'S EXHIBIT 26 ALL-STATE LEGAL SUPPLY CO.

RIVAS, LINDA F/75

NON-INVASIVE VASCULAR LAB

DUPLEX SCAN LOWER EXTREMITY - VENOUS WORKSHEET

Date: 6/3/93 Interpreter: Sankar



DOPPLER

	SPONT	PHASIC	AUG.	VALSALVA
RT:				
CFV				
POP				
LT:				
CFV				
POP				

IMAGING

	NL	NONVZ	CLOT	COAPT	FLOW
RT					
CFV					
SFV					
PRO					
GSV					
PTV					
ATV					
POP					
PER					
LT:					
CFV			✓	P A	
SFV	✓			✓	/--
PRO					
GSV			✓Acute		a
PTV					
ATV					
POP					
PER					

Scan Quality: Right: G F P
Left : G F P

Comments: (L) G.S.U. acute clot extends into C.F.V. + goes proximal No flow in G.S.U. doesn't co-opt
(R) C.F.V. only partial co-opt

VENOUS DUPLEX

Dr. SAWKAR Date 6-21-93

Name PAINO, LINDA Age

Symptoms Severe (L) leg V. Vein's
Alan - Silent TIA ? on Ligation
Palpable cord by (L) knee medial aspect extends
up to mid-thigh reddened & warm

Interpretation

Sup Vein Thrombosis
Sap. System
NO DVT (L)

Interpreted by RSD M.D. DATE 6/22

PLAINTIFF'S EXHIBIT 2D
ALL-STATE LEGAL SUPPLY CO.

FINO, LINDA 7/75
SS# 272-10-7581
80032953
DOB# 8/20/33

PLAINTIFF'S EXHIBIT 2E
ALL-STATE LEGAL SUPPLY CO.

FAIRVIEW GENERAL HOSPITAL
PROVIDING A CIRCLE OF CARE
CLEVELAND. OHIO 44111-5656

VASCULAR LAB REQUISITION

Routine ☐ Today ☐ Urgent Pre-op ☐ Post-op ☐ **OR** Date _____

Requested by Cetin M.D. To be read by _____

Date ordered _____ Date to be done _____

Mode of Transportation: (check one) Wheelchair ☐ Cart ☐ Bedside ☐

VASCULAR DIAGNOSIS: r/o D.V.T (2) leg

ALL PREVIOUS SURGERIES: _____

PROCEDURE REQUESTED:

☐ **CAROTID DUPLEX SCAN**
- ☐ Determine vertebral artery patency
- ☐ Determine direction of opthalmic artery flow

☐ **ARTERIAL DUPLEX SCAN - UPPER EXTEREMITY**
- ☐ Unilateral ☐ Bilateral

☐ **ARTERIAL DUPLEX SCAN - LOWER EXTREMITY**
- ☐ Unilateral ☐ Bilateral
- ☐ Aneurysm ☐ Femoral ☐ Popliteal
- ☐ Graft-specify distal anastomosis

☐ **VENOUS DUPLEX SCAN - UPPER EXTREMITY**
- ☐ Unilateral ☐ Bilateral
- ☐ To include Axillary vein
- ☐ To include Subclavian vein

☒ **VENOUS DUPLEX SCAN - LOWER EXTREMITY**
- ☒ Unilateral ☐ Bilateral

(L)

☐ **VEIN MAPPING**
- ☐ For reverse Saphenous graft or CABG (specify surgery for graft length determination
- ☐ For insitu vein graft (specify surgery for graft length determination)

☐ **PVR - ARTERIAL**
- ☐ Upper extremities
- ☐ Lower extremities
- ☐ Lower extremities with stress

☐ **DIGIT**

☐ **PENILE**

☐ **SPECIAL REQUEST** _____

MEDICATIONS:

☐ Digitalis (Digoxin. Lanoxin) ☐ Atrobrd ☐ Isordli ☐ Inderal

☐ Anticoagulants (circle one) Heparin Coumadin ☐ Peripheral Vasodilators _____

DO NOT **WRITE BELOW THIS LINE** **FOR OFFICE BILLING US€ ONLY**

Test No 1965 Date Completed 12-17-92 Batch No. _____

☐ Carotid Duplex Scan	06708507	☐ Venous Duplex - Upper/Uni	06708101	☐ PVR - Arterial/Upper	06701007
☐ Arteria Duplex - Upper Uni	06707707	☐ Venous Duplex - Upper Bil	06708606	☐ PVR - Arterial/Lower	06702005
☐ Arterial Duplex - Upper Bil	06707608	☒ Venous Duplex - Lower/Uni	06708200	☐ PVR - Arterial/Lower-Stress	06703003
☐ Arteria Duplex - Lower Uni	06707905	☐ Venous Duplex - Lower Bil	06708705	☐ Digit	06705008
☐ Arterial Duplex - Lower Bi	06707806	☐ Vein Mapping	06708903	☐ Penile	06708804

Interpreter's Name _____ BC# 2510

F-3020-712-REV 3 89

200-15

PAINO LINDA 76Y F CAT
SAWKAR RAGHU MD 272107561
000404595
2431 COLUMBIA 44070
CETIN DERRICK C DO

FAIRVIEW GENERAL HOSPITAL
CLEVELAND, OHIO 44111-5659

EACH **NOTE** MUST BE DATED AND SIGNED

PLAINTIFF'S EXHIBIT 26 ALL-STATE LEGAL SUPPLY CO.

DATE	
	Vascular
2/28/95 1:50AM	checked on pt
	Sl. ooze onto dressings
	Drain 25-50cc
Hgb 7.6 will transfuse but I think it's too late to	Has lost PT signal, pt refuses to move toe,
	(L) foot cool & more mottled
	D/W staff,
	Plan - keep on CMD, not
	heparinize yet, observe
	Limb is threatened, graft has
	probably begun to shut down,
	may lose leg below knee
	Siebert
2.28.95	Vascular
6^00	Resting comfortably. Had 2u PRBC
	VS/ 164/63 ; 92; RR=15 ; T=36.4 ; SaO_2=97% ;
	I/O 1165/515 (430 urine; 85 hemovac)
	EXAM
	(L) foot mottled but warm. Minimal
LABS	capillary refill. PT & DP on (L) not
(L)	dopplerable.
	CTA (B) Left seam roles (B)
	RRR.
AM	Stable p surgery; minimal improvement in (L) foot 00010

200-15

PAINO LINDA 76Y F CAT
SAWKAR RAGHU MD 272107661
000404595
2431 COLUMBIA 44070 PVT M NS
CETIN DERRICK C DO

FAIRVIEW GENERAL HOSPITAL
CLEVELAND, OHIO 44111-5659

EACH NOTE MUST BE DATED AND SIGNED

PLAINTIFF'S EXHIBIT 2H
ALL-STATE LEGAL SUPPLY CO.

DATE	
	vascular
2/28/95	VSS
7:20A	(L) foot mottled
#1	pt not want to move
	toes
	some loss of sensory
	No dopplerable signals
	at ankle
	Drain 85cc
	labs pending
	will D/w staff
	[signature]
2/28/95	ICU
"	no complaints this am c/o of (L) foot pain
	VS 90 164/71 92 19
	8/0
	Labs 139/108/13 3.9/27/1.1 277 Mg 1.3 PT 13.2 PTT 23.8 ICA 1.14
	17.4 10.6 31.9 128
	Hrt S_1S_2 (−) 73
	Lung B/L CTA
	Abd soft NTND BS(+) Able to move foot
	ext (−) DP/PT (+) Cap refill warm Sensory absent
	Next Page

00011

200-15

?IIIO LINDA — 75Y F CAT
S?UKAR RAGHU MD 272107?81
002404595
2431 COLUMBIA ?407?

FAIRVIEW GENERAL HOSPITAL
PROVIDING A CIRCLE OF CARE
CLEVELAND, OHIO 44111-5659

PREOPERATIVE NURSING RECORD

DATE	TIME	HEIGHT	WEIGHT	TEMP.	BP	PULSE	RESP.	ALLERGIES	BAND / LABEL
?-?-95	0400		164 lb	36.4 ax	134/53	84	16	NKA	

NURSING ASSESSMENT

MENTAL/EMOTIONAL STATUS
- [x] Alert
- [ ] Sedated
- [ ] Apprehensive
- [ ] Comatose
- [ ] Confused
- [x] Oriented X 4

COMMUNICATION LIMITATIONS
- [x] N/A
- [ ] Retardation
- [ ] Language Barrier
- [ ] Hearing Deficit

MOBILITY
- [x] Moves Well [x] w/Assist
- [ ] Mobilizer Used
- [ ] Painful Joints
- [ ] Joint Prosthesis
- [ ] Physical Disabilities

SKIN
(1) Color
- [x] Norma
- [ ] Cyanotic
- [ ] Flushed
- [ ] Pale
- [ ] Jaundiced
- [ ] Other

(2) Integrity
- [ ] Intact
- [ ] Bruises
- [x] Other (L) leg incision from fem-pop
- [ ] Mottled
- [ ] Rash
- [ ] Reddened Areas

(3) Temp/Condition
- [ ] Cool
- [x] Warm
- [ ] Hot
- [ ] Diaphoretic
- [x] Dry

RESPIRATORY STATUS
- [x] SaO_2 98-100%
- [x] Unlabored
- [ ] SOB on Exertion
- Oxygen Therapy Type 2L NC
- [ ] Smoker ____ ppd X ____ yrs.
- [x] Nonsmoker

DENTITION N/A
- [ ] Good
- [ ] Fair
- [ ] Poor
- [ ] Caps
- [ ] Crowns

INTERVIEW

NPO Since 12 MIDNIGHT

Operative Procedure/Site (L) AKA

Pre-Op Instructions

REVIEW OF MEDICAL RECORD

DIAGNOSTIC TEST	COMPLETED	ON CHART
X-RAY	2-22-95	✓
ECG	2-27-95	✓
LAB	2-28-95	✓
H & P	2-17-95	✓
CONSENT: GENERAL	2-27-95	✓
SPECIAL		

Abnormal results reported to Dr. ____

Type & Screen 3-1

Blood on hold # of units ____

Patient Identification:
- verbal ✓
- armband ✓
- chart ✓
- plate ✓
- cart

PHYSICAL PREPARATION

Removed: ✓ or NA
- Dentures ✓
- ?ts/Glasses ✓
- ?earing Aid N/A
- ? ✓
- ?erson effects ?ured ✓
- Foley ?oided at ?
- Shave prep
- Eye ?iff N/A

Discharge transportation

Family waiting Daughter here

Significant health Hx:
- PUD
- CVD
- HTN
- CAD

Surgical Hx:
- Fem-pop Lt leg 2/27/95
- Angioplasty
- Cardiac Cath 1-3-94
- C-Sections x2

Current medications:
- Norvasc 5mg qd
- Zostrix-Hp cr. qid
- Oruvail 200mg qd

PLAINTIFF'S EXHIBIT 21
ALL-STATE LEGAL SUPPLY CO.

Comments: (See reverse side)

CHECKLIST REVIEWED BY:

PAT/Unit Nurse [signature] RN

Holding Area ____

OR Nurse [signature]

PRE-OP MEDICATIONS GIVEN

MEDICATIONS	DOSE	ROUTE	TIME	INITIALS
Ancef	1gm	IV	1400	[initials]
Zantac	50mg	IV	1400	[initials]
Norvasc	5mg	PO	1000	[initials]
NTG paste	0.?			

F-1520-15000 Rev. 12/94

PREOPERATIVE NURSING RECORD

*** SURGERY SCHEDULE ***

Lewis - OB **Fairview General Hospital** Louise

03/01/95 WEDNESDAY

Veher - ICU

By Scheduled Time

Sm B Dc. Jo Sd R W P Ca Ps U

Ko Veher W K G T Buzatu H C

Time	Surgeon	Patient	Type or Room	Age	Anesthesia Type	Procedure
ROOM 1 Veher U						
08:30	RAJ, PRASANTA	DESSOFFY, RONALD	NB	47	AC	EXC RECURRENT GANGLION CYST, LT WRIST
	PYUN, EDWARD					
TF	RAJ, PRASANTA	JUCHNIK, FLORENCE	NB	62	LOCAL	EXC TUMOR, RT CHEST WALL
	PYUN, EDWARD					
10:30	BOGARD, BRENT	LONG, ROSE	NB	71'	AC	NEEDLE LOC @ 9:00; REM MASS, RT BREAST; F.S
	SHAH, BINITA					(NO MASTECTOMY)
TF	BOGARD, BRENT	MCNALLY, ELEANOR	NB	78*	MAC	DRAIN PLACEMENT LT CHEST WALL
	SHAH, BINITA					
~~11:30~~	~~RAJ, PRASANTA~~	~~SCHULTZ, SOPHIA~~	~~NB~~	~~78*~~	~~AC~~	~~EXC LT BREAST MASS~~ (M/U TF)
						PROB LT MODIFIED RADICAL MASTECTOMY
ROOM 1A T Ps						
08:30	CARAVONA, RONALD	WHITE, BETTY	NB	74*	MAC	CATARACT EXTRACTION, LT; PHACO; IOL
TF	CAWIVONA, RONALD	REIS, WALTER	NB	79'	MAC	CATARACT EXTRACTION, RT; PHACO; IOL
TF	CARAVONA, RONALD	HALUPNIK, GLORIA	NB	63	MAC	SECONDARY IMPLANT, RT
TF	CARAVONA, RONALD	LIEB, RAY	NB	71'	MAC	CATARACT EXTRACTION, LT; PHACO; IOL
TF	CARAVELLA, LOUIS	BREYLEY, LEONA	NE	79*	MAC	CATARACT EXTRACTION, RT; PHACO; IOL
TF	CARAVELLA, LOUIS	SIDDALL, MARIAN	NB	83*	MAC	CATARACT EXTRACTION, RT; PHACO; IOL
TF	CARAVELLA, LOUIS	ALLEN, KATHERINE	NB	56	MAC	CATARACT EXTRACTION, LT; PHACO; IOL
TF	CARAVELLA, LOUIS	JACZYNSKI, THEODORE	NB	70*	MAC	RE SUTURE WOUND, LT EYE
ROOM 2 Veher P						
08:30	BINDER, JEFFREY	SCELZA, MEGAN	NB	11M	AC	TYMPANOSTOMY W TUBES; BILATERAL
TF	BINDER, JEFFREY	MURPHY, STEPHANIE M.	NB	3	AC	BIL TYMPANOSTOMY W TUBES
TF	BINDER, JEFFREY	WITHERSPOON, COLLEEN M.	NB	5	AC	BIL TYMPANOSTOMY W TUBES
						S ADENOIDECTOMY
TF	BINDER, JEFFREY	SCHIAZZA, JULIANNE T.	NB	9	AC	A T&A
TF	BINDER, JEFFREY	GEISE, ROBERT	NB	59	AC	SEPTOPLASTY
13:30	DEOUBI	MCWEENY, CHARLES	423-1	65*	MAC	MEDIPORT INSERTION (C-ARM) EB.
ROOM 2A T Ca						
08:30	MEHLE, MARK	GANCHAR, CODY	NB	3	AC	BIL TYMPANOSTOMY W TUBES
						ADENOIDECTOMY
	MEHLE, MARK	BOOTH, THOMAS	OV	46	AC	OSTEOPLASTIC FLAP OF FRONTAL SINUS; POSS
	DALAGIANNIS, TOM					ABDOMINAL FAT GRAFT
						SEPTOPLASTY
.. 30	CHOI, CHARLES	RAPACZ, LOUIS	NB	86	AC	LUMBAR EPIDURAL NERVE BLOCK
TF	Choi	Flickinger Dorothy 327-2477	NB	50	AC	PVL96 (C-Arm)
ROOM 3 H W						
08:30	VERIKIS, KALLINIKI	MIHALEK, FRANCES	AM	74*	AC	VAGINAL HYSTERECTOMY; AP REPAIR
	HARRIS, PRESTON					
	KARIKAS, HELEN					
12:00	ANESTHESIA	ANES			AC	ANES TO MRI-1YR
13:00	MAKII, MICHAEL	BEAMISH, DIANE	326-2	37	AC	EXPLORATORY LAPAROTOMY
	MARKULY, SOTIRIOS					
						TAH; BSO; F.S.
						OMENTECTOMY
						APPENDECTOMY
						LYMPH NODE DISSECTION; TUMOR DEBULKING
						(BOOKWALTER)
ROOM 4 H Sd 9:00 anes Cuneo Capota						
~~08:30~~	~~FREEMAN, RICHARD~~	~~BRINK, BRIAN~~	~~NB~~	~~17~~	~~AC~~	~~BIL TYMPANOSTOMY W TUBES~~ 11 OB
9:30	ANESTHESIA (TF Dr. Gamerman)	***			AC	COVER CYSTO
10:30	KATIGBAK, EDGARDO	PAGE, EDMONIA	NB	52	AC	FX D&C
	KARIKAS, HELEN					
12:00	HAFTKOWYCZ, ERAST	WITHERINGTON, CECILIA	AM	46	AC	D&C; HYSTEROSCOPY
	KARIKAS, HELEN					

C/C

LAT

PLAINTIFF'S EXHIBIT 2J

	GAHRING, STANLEY	ATWELL, BARBARA	NB	49	LOCAL	CYSTOSCOPY; CYSTOMETRICS	(Anne Rm 4)
	MORSE, REID	HOSTETLER, ABSOLUM	NB	76*	AC	CYSTO; TUR BLADDER TUMOR; BIL RETROGRADE PYELOGRAMS (ANES/RM 4)	
10:30	MORSE, REID	D'AGOSTINO, CARMELO	NB	36	LOCAL	CYSTOSCOPY	
11:30	MORSE, REID	MILLER, DEAN	NB	37	LOCAL	FLEXIBLE CYSTOSCOPY	
12:30	MORSE	DRISCOLL, SHERRY		38	LOCAL	CYSTO; CYSTOMETRICS; CYSTOGRAM ER	
	TF SAWKAR - see below						
	SAWKAR, RAGHU KATRIS, FRANCES	LING, RONALD #1	626-2	62	AC	LT FEMORAL TIBIAL BYPASS GRAFT	
8/14:30	LOCKHART, CURTIS	GERENGKER, PAUL	AM	46	AC	RT ILIAC FEMORAL BYPASS GRAFT POSS BALLOON ANGIOPLASTY (C-Arm)	
	TF Sawkar	Paino, Linda #2	[illegible]	76*	AC	LT AK AMPUTATION	

ROOM 6

09:30	HAZEN, PAUL	HACE, PATRICK	NB	13	LOCAL	CO2 LASER M C INGROWN NAIL, LT GREAT TOE
TF	HAZEN, PAUL	DANIEL, RICKARD	NE	46	AC	CO2 LASER EXC GIANT WART, LT GROIN
12 00	MOURAD, WILLIAM OLITSKY, DAVID	THOMAS, STEPHEN	NB	25	AC	ARTHROSCOPY, LT KNEE

14:30 Lockhart FROM RM 5 — LATE

ROOM 7

08 30	ANESTHESIA	...			AC	ANGIOPLASTY X 1; POSS ANGIOPLASTY X 1

ROOM 8

08 30	POOLOS PETE LIEDERBACH CHRISTOPHER	MINADEO, DONALD II	NE	31	AC	CERVICAL LAMINECTOMY, C5-6, RT DISCECTOMY
TF	POOLOS, PETE ~~LIEDERBACH, CHRISTOPHER~~ Patterson	JUSTICE CHRISTOPHER	NE	25	AC	DECOMPRESSIVE LUMBAR LAMINECTOMY, L5, S1 RT

C/CSED

ROOM 9

08:30	BEG, RAIS A APTE, SUSAN Patterson	HARGIS, MARIE H.	KCU	64	AC	REDO CABG X 2 RESECTION L V ANEURSYM

LATE

10 WC 13

08 30	RADKOWSKI CASIMER MILLER TERRI TAYLOR CHICO	TRUHAN GEORGE	601-3	61	AC	TOTAL RT KNEE REPLACEMENT
TF	RADKOWSKI CASIMER MILLER TERRI TAYLOR CHICO	THOMMA, FLORENCE J.	AH	62	AC	ROTATOR CUFF REPAIR, LT SHOULDER (MIDAS REX)

ROOM 11 WC 12

08 30	MAGISANO, JAMES BROWN, TRUDI Bray Cary	MURPHY, TERESA	NB	27	AC	LAPAROSCOPIC CHOLECYSTECTOMY
TF	MAGISANO, JAMES BROWN TRUDI	BASCH, MARY ANNE	NE	66'	AC	NEEDLE LOC @ 8:00; REM MASS, RT BREAST (NO MASTECTOMY)
12 30	MCLAUGHLIN, DANIEL KATRIS, FRANCES Florian Breyley Patters	SCHWARTZ, ANDREW	229-1	74*	AC	LT FEMORAL POPLITEAL BYPASS GRAFT SAPHALIC VEIN GRAFT

LATE

ROOM 12 C

08:30	DAVIS, ALLAN KELLEHER, PAUL SZCZEPINSKI, KIM	COLE, JEFFREY L.	NB	33	AC	LT DAK, ACL RECONSTRUCTION

BIRTH CN Ko

08:30	KATIGBAK, EDGARDO	BARSA, MARIA	AM	30	AC	REPEAT C-SECTION TUBAL LIGATION
10:30	CHAHO, AMY	PERKINS, GERALDINE	NE	27	AC	PRIMARY C SECTION
	RALMOBAYED	SAJOVIC, PAMELA	AM	35	AC	REPEAT C-SECTION ER

ROOM 8

1900	Horwood Florian (Req 6pm)	GARLITZ, DORIS E. 614-1		69	AC	ORIF; LT Hip Fx (Chick TABLE, C-Arm)

HOLD

	TF SAWKAR Corpus	WINTER, ELAINE 514-1 281-4411		62	AC	DEBRIDEMENT, NON HEALING INCISION, RT LEG

FAIRVIEW GENERAL HOSPITAL
CLEVELAND, OHIO 44111-5659

EACH NOTE MUST BE DATED AND SIGNED

PLAINTIFF'S EXHIBIT 2K
ALL-STATE LEGAL SUPPLY CO.

DATE	
3-1-95	Vascular Surgery
0530	AVSS NAD A+Ox4
	I/O: 3850/2700 (+1155)
	(shift): 575/900 (-325)
	HV: 100 (bloody)
	UOP: 2600 ⇒ 900
	Neuro- ∅ sensory Ⓛ LE, Above knee
	Pulm- CTA Ⓑ O_2 sat 95-98%
	CV- NSR RRR
	GI- benign
	Vascular- Ⓛ LE below knee mottled, cool,
	∅ PT/DP pulses.
	Incisions- inferior: C.D.I.
	superior: minimally serosang oozing
Ⓐ	/Ⓟ Ischemic Ⓛ LE. Scheduled
	for BKA today. F/U labs.
	Tom Cappa - MS

00013

PATIENT:	PAINO, LINDA
MR NO.:	01030925
PHYSICIAN:	B. DROUBI, M.D.
DATE OF ADM.:	02/27/95
DATE OF DIS.:	05/02/95
HOSP. SVC.:	SRG

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PLAINTIFF'S EXHIBIT 21
ALL-STATE LEGAL SUPPLY CO

FINAL DIAGNOSES: Left femoropopliteal stenosis, with failed angioplasty, revascularization with Gore-Tex graft, revascularization with femorotibial reverse saphenous vein graft, and prolonged postoperative care of necrotic left leg and thigh incisions.

HISTORY AND HOSPITAL COURSE: This patient was admitted under the care of Dr. R. Sawkar for revascularization using balloon angioplasty of the left leg femoropopliteal artery. The patient post-angioplasty thrombosed her femoropopliteal artery, and attempted revascularization by Dr. Sawkar using Gore-Tex graft ended with thrombosis of the graft. The leg became markedly ischemic, with foot drop and ischemic necrosis of the skin edges of the incisions, and also of the calf muscles. I was called to evaluate the patient on 03/01/95 at 03:30 p.m. because the patient refused the decision of Dr. Sawkar to perform above knee amputation. The family called me in as a second opinion for attempt at revascularization.

When the patient was seen in the Intensive Care Unit, she was in severe pain of the left leg and foot, with foot drop and inability to have dorsiflexion of the ankle. There was extensive cutaneous necrosis of the medial calf and thigh incisions.

At this point, we had a conference with the patient and the family regarding the options of treatment. I did agree initially for the amputation; however, I had discussed with them that I may attempt to re-explore the tibial arteries and evaluate the possibility of revascularization if the tibial artery appeared to be patent. If the artery was not patent and thrombosed, then above knee amputation would be carried out. The patient was taken to the operating room the same day, where exploration of the tibial artery was done. Doing arteriogram intraoperatively revealed a patent posterior tibial artery to the ankle. At this point, the family was then contacted from the operating room and informed that the functional capacity of the leg was extremely limited due to the presence of the foot drop and the muscle necrosis, and were told that her full functional capacity may not be recovered in spite of the revascularization. The family and the patient were adamant about the attempt to revascularize even in the absence of functional leg to preserve the leg if we could. For that reason, harvesting of the right leg saphenous vein was done, and revascularization of the leg was done using a emo oral-posterior tibial bypass graft, Postoperatively the patient had a prolonged postoperative course. Her perfusion of the lower extremity markedly improved, with a palpable pulse in the posterior tibial artery. However, the complication which occurred was that of necrosis of the incision and muscle that had occurred preoperatively from the severe ischemia for 48 hours. This required multiple explorations and debridements, and at that point I called for the help of Dr. T. Ghazoul, a plastic surgeon, in order to achieve coverage of the exposed graft that occurred following the frequent debridements of the gastrocnemius necrotic muscle fibers and the soleus muscle fibers. With repeated debridements and

RESIDENT ATTENDING B. Droubi 00003

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coverage, eventually the patient had only a sinus opening, which was treated aggressively with local care. The patient was then transferred to the extended care facility.

Rehabilitation started with Physical Therapy evaluation and aggressive treatment. Near the discharge date, the patient was doing fairly well. She had no symptoms of pain in the left foot and ankle, although her functional ability was markedly limited. Her incisions and skin grafts were showing marked healing and improvement, and at this point the patient was transferred to the nursing home to continue her physical therapy and to follow in the office with me and with Dr. Ghazoul.

Dictated by: B. DROUBI, M.D./KC
D: 10/10/95
T: 10/24/95 12:36
cc: R. SAWKAR, H.D.
D. CETIN, D.O.

RESIDENT ATTENDING

00004

CURRICULUM VITAE

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

Office: 1925 W. Orange Grove Rd., Ste. 100-101 (520) 742-8944
Tucson, AZ 85704

Home: 5931 E. Finisterra Dr. (520) 529-9234
Tucson, AZ 85750

DATE AND PLACE OF BIRTH

November 19, 1949 Cleveland, Ohio

EDUCATION

High School:	Cleveland Heights High School	1967
Undergraduate:	Northwestern University - B.A.	1971
Medical School:	Ohio State University College of Medicine - M.D.	1974
Residency:	Northwestern University Hospitals - General and Vascular Surgery	1974-1979

PERSONAL

Married: Sharon Kagan Pitluk
Ohio State University - B.A., Elementary Education - 1971
John Caroll University - M.A., Guidance and Counseling - 1991

Children: Adam Seth - born August 18, 1976
Jessica Danielle - born May 28, 1979

AWARDS

Dean's List - three of four years - Northwestern University, Evanston, Illinois

Letter of Commendation - Ohio State University, Department of Medicine 1973

Annual Surgical Award - Northwestern University Medical School 1979

CHAPTERS AND VIDEO PRODUCTIONS

1. "Fern-Pop Bypass with Gore-Tex Suture and Graft" for W. L. Gore and Associates, 1984 (Video).

2. "Carotid Endarterectomy with Gore-Tex Patch Angioplasty" for W. L. Gore and Associates, 1989 (Video).
3. Hemodynamic and Respiratory Monitoring, The Handbook of Critical Care, co-author J. E. Sampliner, M.D., 2nd Edition.
4. General Care of the Critically Ill Patient, The Handbook of Critical Care, co-authors, J. E. Sampliner, M.D., R. E. Sampliner, M.D., 3rd Edition, 1990, Little-Brown & Co.

REFERRED JOURNAL ARTICLES

1. Pitluk, H. C.: Constrictive Pericarditis. Ill. St. Med. J. 155:165; 1979.
2. Pitluk, H. C.: Hemangioperlcytoma. Am. J. Surg. 137:413-16; 1979.
3. Pitluk, H. C.: Acute Cholecystitis with Choledocholithiasis. Proc. Instit. Med. Chicago 32:105; 1979.
4. Pitluk, H. C.: Choledocholithiasis Associated with Acute Cholecystitis. Arch. Surg. 14:887-889; 1979.
5. Pitluk, H. C.: Intra-Abdominal Mesenteric Desmoid Tumors. Am. Surg. 48:316-319; 1982.
6. Pitluk, H. C.: Carcinoma of the Colon in People Under 40 Years Old. SGO 157:335-339; 1983.
7. Pitiuk, H. C., Rubin, J. R., King, T. A., Hutton, M., Kieger, E. F., Plecha, F. R., Hertzer, N. R.: Carotid Endarterectomy in a Metropolitan Community: The Early Results After 8,535 Operations. J. Vasc. Surg. 7:256-260; 1988.
8. Pitluk, H. C., Rubin, J. R.: Do Operative Results Justify Tibial Artery Reconstruction in the Presence of Pedal Sepsis? Am. J. Surg. 156:144; 1988.
9. Pitluk, H. C.: Spontaneous Hepatic Rupture Associated with Peliosis Hepatitis. Submitted.
10 Pitluk, H. C., Plecha, E. J., Rubin, J. R., King, T. A.: Risk Assessment for Patients Undergoing Carotid Endarterectomy. Accepted J. Cardiovasc. Surg.; 1991.
11 Pitluk, H. C., Aldrich, R., LoPresti, C., Fumich, M., O'Brien, W.: Pseudoaneurysm Complicating Knee Arthroscopy. Arthroscopy: The Journal of Arthroscopic and Related Surgery. April 1995.

MEDICAL LICENSURES

Ohio	No. 97637	June 1974
California	No. C37963	August 1978
Arizona	No. 23149	May 1995

SPECIALTY CERTIFICATION

Laser Centers of America
- Applications of Lasers in General Surgery -- June 1989
- Applications of Lasers in Physics, Tissue and Safety -- May 1989
- Operative Laparoscopy and Laser Laparoscopic Cholecystectomy -- April 1990

Board Certification
- American Board of Surgery - Certificate No. 28250 -- November 1982
- American Board of Surgery - Recertified -- October 1992

SERVICE TO THE UNIVERSITY

Emergency Room Committee, Northwestern University Medical Center, Chicago, Illinois	1976
Clinical Instructor, Department of Surgery, Northwestern University Medical Center	1979
Clinical Instructor, Department of Surgery, Case Western Reserve University	1980-1990
Assistant Clinical Professor, Department of Surgery, Case Western Reserve University	1991-present

MEMBERSHIPS AND OFFICES IN PROFESSIONAL SOCIETIES

Academy of Medicine of Cleveland----------1979

Diplomat of The American Board of Surgery----------1982

The Cleveland Surgical Society----------1983

Fellow of The American College of Surgeons----------1984

The Society for Clinical Vascular Surgery----------1984
Membership Committee (1987), Membership Committee (1990), Chairman Bylaws Committee (1991), Member at Large (1993), Executive Committee (1991-present)

The Cleveland Vascular Society----------1984
Program Chairman (1985-1986), Program Chairman (1989-1990), Treasurer (1991), Secretary (1990), President (1993-1994)

Midwestern Vascular Surgical Society----------1994

PRESENTATIONS

Co-Presentation -- Carotid Endarterectomy in a Metropolitan Community: The Early Results After 8,535 Operations. The Society for Vascular Surgery, Toronto, Canada, June 1987.

Co-Presentation -- Femoral-Tibial Bypass for Limb Salvage. The Society for Clinical Vascular Surgery, Maui, Hawaii, April 1988.

INVITED PRESENTATIONS

Presentation -- Raynaud's Disease. Channel 5 Morning Exchange Television Appearance, 1987.

Presentation -- Acute Appendicitis. Channel 5 Morning Exchange Television Appearance, 1988.

Presentation -- Carotid Endarterectomy. "Medical Tomorrow" Channel 8 Morning News Television Appearance, 1990.

Presentation -- Cooper Vapor Laser Sclerotherapy. "Medical Tomorrow" Channel 8 Morning News Television Appearance, 1990.

Presentation -- Carotid Surgery and the Prevention of Stroke. Medical Update WCLV Radio, 1990.