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

IN THE COURT OF COMMON PLEAS

BELINDA HALL, ADMINISTRATRIX *of*)
the ESTATE of DELMAR DARRELL,
Plaintiff,)
vs.) Case No. *363835*
)
KAISER PERMANENTE, et al.,)
)
Defendants.)

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THE DEPOSITION OF JEFFREY L. PONSKY, M.D.
WEDNESDAY, OCTOBER 20, 1999

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The deposition of JEFFREY L. PGNSKY, M.D., called by the Plaintiff for examination pursuant to the Ohio Rules of Civil Procedure, taken before me, the undersigned, Robert J. Wanous, Notary Public within and for the State of Ghio, taken at the Cleveland Clinic, 9500 Euclid Avenue, Cleveland Ohio, commencing at 3:05 p.m., the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiff:

William Hawal, **Esq.**
Stuart E. Scott, Esq.
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and
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On behalf of the Defendants:

Beverly Sandacz, Esq.
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JEFFREY L. PONSKY, M.D.

of lawful age, called by the Plaintiff for examination, pursuant to the Ohio Rules of Civil Procedure, having been first duly sworn, as hereinafter certified, was examined and testified as follows:

EXAMINATION OF JEFFREY L. PONSKY, M.D.

BY MR. HAWAL:

Q Please state your full name, Doctor.

A Jeffrey Lawrence Ponsky.

Q I presume you have testified by way of deposition in the past?

A Yes.

Q If at any time my questions aren't clear, you don't understand what I am asking, please let me know. All right?

A Okay.

Q Thank you. I am just going to ask you what you have reviewed as a part of your consultation in this case? And your secretary just brought in a stack of materials.

A Right.

Q And this would be your file.

A Yes, it has been awhile since I reviewed every

aspect of it but I read it all.

Q That would include the deposition of Dr. McCalla?

A Yes.

Q Two volumes of the chart of various medical records for Mr. Darrell?

A Yes.

Q Anything else other than the materials that I have just identified?

A I don't believe so.

Q Have you looked at the deposition transcripts of Drs. Vogten and Brown?

A Yes. Yes. Yes. They are not there. I have read them. I read those earlier.

Q And ultimately you prepared a report that I believe you have in front of you, dated June 29th, 1999?

A Exactly. Correct.

Q Is that the one and only report you have prepared?

A Yes.

Q Are there any other drafts of this report that are available?

A No.

Q How many times have you testified as an expert

witness in the past?

A By, you know, deposition?

Q Deposition.

A Or anything?

Q Or at trial?

A A lot. I don t know. Perhaps 15.

Q All right. And has that been primarily since you have been here at the Cleveland Clinic?

A No.

Q A lot of that'was preexisting your tenure here at the Clinic?

A Yes.

Q Have any been for the plaintiff?

A Yes.

Q What percentage would you estimate for the plaintiff versus the defendant?

A Maybe 15 percent.

Q For the plaintiff?

A Uh-huh.

Q Have any of your prior depositions as an expert involved issues relating to PEG and specifically relating to complications of bowel perforation, that come to mind?

A Well, the funny thing is I review a lot of these cases, some of them never get to the deposition

or court and I can't remember -- a lot of them are involving PEG.

Q All right.

A But I don't remember how many of them actually went to anything.

Q Got you. Of the ones that you have reviewed that you recall involving PEG, do any of them involve transection of the colon?

A You mean perforation of the colon?

Q Perforation of the colon, right?

A I believe one or two may have, yes.

Q Would those have been defense cases or cases in which you were retained by the defendant?

A Defense, yes. Yes.

Q Is it fair to say that you have a particular interest in PEG?

A Yes.

Q And that has been true since about 1980?

A 1979.

Q '79? All right. And what was your position at Mt. Sinai at that point in time?

A Well, I was the director of the Department of Surgery there.

Q All right. And Dr. Gouder was a colleague of yours in that department?

A No, Dr. Gouder and I worked together a month or so before -- we worked for years before, but we did the first PEG about two months before I went to Mt. Sinai. I was at Case Western Reserve, University Hospitals.

Q Okay. And was Dr. Gouder your elder or superior or contemporary?

A Contemporary.

Q What was Dr. Gouder's role relative to yours or Dr. Izant's, with regard to development?

A Dr. Izant did nothing in the development of it. He was just our friend. He was the senior pediatric surgeon there. So we put him on the paper. Dr. Gouder and I designed every aspect of the procedure together.

Q If you were to describe your shared responsibility, how would you?

A 50/50.

Q You have written rather extensively on PEG since that time?

A Yes.

Q Would it be fair that the technique for PEG has been improved and refined since 1980?

A In small ways.

Q Okay. There has been some evolutionary change?

A Yes.

Q In the procedure?

A Yes. Yes.

Q And that change has come about as a consequence of the global experience of physicians like you and the reporting of those experiences in the medical literature?

A Yes.

Q I take it that part of your goal and part of the goal of your colleagues who have a particular interest in PEG, in reporting your experience into the literature, is to improve with regard to morbidity and mortality for others that are learning about PEG placement?

A Yes.

Q Would it be fair to say, Doctor, that the standard of care with regard to PEG placement has in fact evolved as a consequence of your contributions and the contributions of others to the body of medical literature about PEG?

A Yes.

a Would you agree that some complications from invasive procedures like PEG can be improved or reduced by meticulous surgical technique?

MS. SANDACZ: Objection. Go

ahead.

A Yes.

Q When you first described this procedure in your medical publication, I believe that you described it as simple, safe and rapid. Do you recall that?

A Uh-huh.

Q Yes?

A Yes.

Q You initially did not describe the procedure to include transillumination? In your initial publication?

A It has been a long time since I have looked at that particular article. Very soon after the original article, we did describe transillumination.

Q But initially, transillumination was not described as the first published description of the PEG?

A In the first description.

Q Okay. But soon thereafter, you had described and promoted transillumination as a technique for PEG?

A Yes.

Q And why was that?

A Well, we used transillumination from the first time. I don't have the original publication before me now. If you do, I would love to look at it.

Q Sure, I do.

A Because I've written so much about it, but early on, even in the first case, we used transillumination quite extensively, because it was important in identifying the site of a puncture. And this is the one that we pushed in pediatric surgery. Let's just see. Yes. It speaks about transillumination indirectly and even the first one, it says if the lights in the room are dimmed the gastric contour and gastroscope can be discerned. So that refers to what we were doing in terms of transillumination. That is why we dim the lights in the room. 1 knew we mentioned it in some way, even in that one.

Q But ultimately it became more of a focus of your writings and those of others, from the standpoint of it being described as an integral part of the procedure?

A Yes.

Q And that would be a safety measure, correct?

A It was.

Q And what transillumination was being promoted to prevent, would De to prevent complications with regard to bowel perforation?

A That is the idea. That is the idea.

Q Transillumination ultimately did become the standard of care for endoscopists performing PEG?

A For awhile.

Q Is it still the standard *of* care?

A No. There is a reason for that, by the way. Which--

Q Okay.

A Which I write about in my recent writings. In fact, I just finished a chapter and that is in the knew gastroscopes, the video gastroscopes don't provide as bright a light to transilluminate and in some patients you just can't transilluminate, so we use different measures now.

Q Do you know what kind *of* scope was used? Was **a** video scope used in this procedure?

A You know, I don't know that answer. I don't know the answer.

Q Later, correct me if I am wrong, after you

initially described this procedure and then began to describe transillumination as part *of* the -- go ahead.

A Please let me interrupt you. It was video endoscope.

Q Sure. All right. So basically what evolved with the advent of video endoscope is that transillumination became less valuable as a safety tool because of the quality of the light that was transilluminating the abdominal wall?

A Yes, we used other things instead.

Q So transillumination via video endoscope would not be satisfactory for being utilized as the sole safety precaution?

A Right.

Q All right. Later you recommended, correct me if I am wrong, endoscopically visualized abdominal palpation?

A Right.

Q And that was utilized as a secondary or additional precautionary measure to prevent bowel perforation during PEG placement?

A I think it helps optimize the best site, yes.

Q You have reported in the literature over the years, your own personal experiences with your

patient populations and with regard to PEG procedures?

A Yes.

Q And I take it that one of the reasons for that is to educate your colleagues, both with regard to the risks that they can expect with the procedure and what steps they can best take to avoid or minimize those risks, correct?

A Right.

Q Can you again -- I know this is going to be probably a very general estimate, but can you give me an estimate as to the number of PEGS that you personally placed or participated in?

A Probably a thousand.

Q If not more?

A Yeah.

Q Would I be correct in saying that of all the publications that you have contributed to the body of the medical literature on PEG, you have not described one particular patient of yours who has sustained bowel perforation during PEG placement?

A I don't think that is correct. Because we did report, Mike and I reported, I think, two gastrocolic fistulas, with PEG.

Q And when was that in relationship to present day?

A Early on

Q Early on?

A Yes We did report. I can think of two one in a child and one in an adult

Q All right. And that would have been as this PEG procedure was first being developed or within several years of that time?

A It was within several years of that time.

Q But since then you have not had that experience, correct?

A Not to my knowledge

Q All right Doctor, can gastrocolic fistulas develop as a later complication of PEG placement rather than an acute bowel perforation during the procedure. performance of the initial procedure itself?

A The most common reason it occurs is because the bowel is injured with the original PEG itself Very often. I don't even know about it until the tube is changed Because the colon can be done through and through into the stomach and then when they change the tube, the tube is then placed into the first lumen it comes to. which

is the colon. So then they appear with diarrhea. That can be a year later. Sometimes they just have diarrhea right within a few weeks. But in rare cases, pinching of the colon or erosion of the colon adjacent to the gastrostomy can cause the fistula.

Q And in terms of the two patients that you described, you do not know if the former or the latter occurred?

A I think in both of them, I can honestly say I think we punctured the colon.

Q Does the procedure entail elevating the patient's head?

A I don't.

Q You don't?

A

Q Well, that is a frequently described --

A A lot of people do.

Q component?

A Yes, a lot of people do.

Q And what is the purpose *of* that?

A The idea is to let gravity pull the stomach down away from the rib cage a little bit so you have better access for it.

Q Isn't it also thought to displace the bowel away

from the stomach?

A I don't know.

Q The bowel contains air, correct?

A Yes.

Q And that is universally accepted?

A That the bowel contains air? Yes. Not all of the bowel is filled all the time, but the bowel has air in it for sure.

Q Isn't it generally recognized among endoscopists who perform, or surgeons or who perform the PEG, that when you position the patient with the head or torso elevated, what you are going to do is you are going to cause air to migrate or find its way to the upper reaches of the bowel rather than have it in the lower reaches of the bowel; is that not correct?

A You know, I never thought about it. I never even considered where the air is in the bowel when I do a PEG. Except that we don't want to over distend the bowel and we -- I understand why people elevate the head of the bed. I understand it. I don't use it.

Q Let me ask you, if a physician who is performing the PEG carefully transilluminates the bowel or, I am sorry, transilluminates with the

endoscopist and does the finger palpation technique that is advocated, how does one do that and get a perforation of the bowel?

A My impression of how this happens at times is that the colon is not necessarily perforated directly but pinched. And that it is squeezed. It intervenes as the stomach is pulled up into the abdominal wall and that it is pinched in between the stomach and the abdominal wall and can become necrotic and perforate. I think that can happen even though you localize the site.

Q Transecting the center of the transverse colon, perforating it during a PEG, if you are using transillumination and finger palpation, should not occur, correct?

A It can occur.

Q It can?

A It can. And that is one of the reasons why people, as I said, have reported that when they change the tube it enters the lumen of the colon directly.

Q Can it occur in patients who do not have abdominal adhesions from prior surgery?

A Yes, it can.

Q And you base that statement on what?

A I have photographs showing it.

Q Well, you indicate -- do you have photographs of it from your own personal patients?

A No. people send me these cases.

Q Let me ask you if you agree with this statement: Careful attention to selection of the site for abdominal puncture by seeking clear transillumination of the abdominal wall has prevented puncture of organs adjacent to the stomach. Do you agree with that statement?

A It has in most cases, yes.

Q And is it more important for the endoscopist and his assistant to pay careful attention to detail during this procedure?

A Of course.

Q Is prior laparotomy a contraindication to PEG?

A No

Q Do certain additional precautions need to be taken in a patient who has a prior laparotomy?

A I think the procedure is the same. I used myself techniques that have been published before, which very few people use, that I keep writing about now more and more, to even enhance the safety of it. And if I can tell you about it. There is a technique that is published in the

literature that almost nobody uses. And I didn't push it. It was produced by a fellow named Foucth, F-o-u-c-t-h, which is called the safe track technique.

Q I will get that to that. Right.

A I use this procedure routinely. I believe it helps prevent the type of perforation that you talk about. I write about it extensively. And in my experience with excellent endoscopists throughout the world, it is rarely used by them. I am trying to change that. But to this date, I can tell you that it is not used widely.

Q And how do you come to that conclusion, Doctor by speaking to people?

A Yes. I go around to all these meetings: and I show this and talk about it. And for whatever reason, people have had such good success with the way they do PEG, based on the original description, that they don't want to do it or they don't do it.

Q In fact, Dr. Foucth first described this procedure in 1988?

A Yes. It is a great procedure.

Q Oh, so it has been in the medical -- it has been in the fountain of medical knowledge since that

time?

A Oh, yes.

Q And it is well recognized among endoscopists who perform this?

A No, it is not. That is the problem. I lecture about this procedure, because I use it routinely. And I don't believe that it is well recognized. And I keep writing about it. And I just wrote about it again. And it is not -- it is a wonderful addition, and it is not widely used.

Q And the specific purpose why Dr. Foucth described and advocated this procedure was to eliminate even the possibility of bowel perforation during this procedure, correct?

A Well, I think that is a bold statement. But I think he wanted to minimize. If Dr. Foucth stated that, I think he overstated it. But certainly that is the purpose of it, to reduce the possibility. Everything we do, the possibility is to reduce. I think if anybody has a zero complication rate from any procedure, I want to meet him.

Q Well, we talk about complication rates and we talk about -- there are different kinds of

complications that can occur from PEG placement, correct?

A Exactly. But I am even talking about bowel perforation.

Q Some complications are more common than others, correct?

A Yes.

Q Infection is one of the accepted risks?

A It is more common.

Q Of this procedure?

A Right.

Q Doctor, you have reviewed the records in this case relating to this PEG procedure, correct?

A Right.

Q There is not *an* operative report which describes the procedure and all of the steps that the endoscopist and his assistant utilized during this procedure, correct?

A There is no formal operative report.

Q There is no indication as to whether transillumination was used as a technique?

A Correct. That is correct.

Q There is no indication as to whether or not a finger palpation technique was used, correct?

A That is correct.

Q And there is no indication that the safe track technique was used, correct?

A That is correct.

Q So based upon your review of the operative note, you cannot testify that there was not a deviation from the standard of care in the way in which this procedure was carried on on Delmar Darrell, is that fair?

A Within certain constraints, that is true. There are other things in here that give me some idea, not all ideas, some ideas. And those have to do with their description. This exhibit here shows. It is the endoscopy report. And there is an endoscopy report. I will tell you, even at the world famous Cleveland Clinic where we sit right now, we do endoscopy reports at this time on computer. And there is a move towards these reports. And it was what this one is right now. And this one does say that the scope was reinserted and the head of the catheter was visualized. I think this is the one that I am looking at. Let's see. Is this the one?

MS. SANDACZ: Here.

[Indicating.]

A Yes. Under complications. It says second EGT

scope in stomach in situ. No bleeding. So I can tell they did pass the scope the second time. One of the problems I find with some people who do PEGS, they don't put the scope in the second time as we described, they pull the tube down and quit. Sometimes people have actually pulled the tube out too far and perforated the stomach that way. And they don't know, because they haven't reinserted the scope to see if the scope is in the stomach. In this case at least, they did that, i can tell you chat.

Q And you were aware that neither of these physicians recalls this particular procedure that was performed on Mr. Darrell?

A I wasn't aware. I don't remember that fact. I don't recall it.

Q Well, assume for the sake of this deposition that each testified that they did not have any recollection.

A Of the particular --

Q Of this particular procedure.

A Okay

MS. SANDACZ: Particular patient, but go ahead.

Q And that is one of the reasons why operative reports are important, is to document for physicians who are not going to have a recollection of a procedure some weeks, months or years later, correct?

MS. SANDACZ: Objection. *Go* ahead.

A That is the idea, yes.

Q Doctor, the reports of bowel perforation in the literature, would you agree that they are anecdotal reports?

MS. SANDACZ: Objection. *Go* ahead.

A Not entirely. They are part of a series that have been reported. In other words, they may be anecdotal in some cases and in other cases people reported them as part of their review of their data.

Q Can reports of complications in the literature, particularly if they are very rare complications, be contributed to by variable skills related to performance of the procedure, technical variables as well as variable skills of the physicians involved?

MS. SANDACZ: Objection. Go

ahead.

A In some cases, that is true.

Q Bowel injury during PEG can be the result of the departure from accepted techniques and standards of care?

A Yes.

Q Have you ever seen that happen or ever -- and I don't mean first-hand knowledge from the standpoint of witnessing it, but having seen it from either medical records or descriptions provided to you by anyone?

A Not directly, that I can tell you about. I don't have enough knowledge of each individual case.

Q Can you state that any reported incident of bowel perforation described in the literature that occurred as a direct result of perforation of the colon during PEG placement was not the result of deviations from accepted technique?

A Not knowing every single case and not being there, I can't state that.

Q Right.

A I can only speak for the ones that I have performed with Dr. Gouder in the beginning, in which we thought we did the accepted technique,

and we were very careful and we still had a certain incidence *of* this complication. And I think that there are other people, who I consider reasonably good endoscopists, who have reported some problem, although I don't know the percentage of cases.

Q Would it be fair to say that you, since you began utilizing the safe track technique, have not had those complications, correct?

A To my knowledge, that is *so.*

Q And isn't it true that there is not a single report in the literature of anyone having this complication since the - contemporaneously with the use *of* the safe track technique?

MS. SANDACZ: Objection.

A I don't know all the literature on that particular variable.

Q All I can ask you is what you are familiar with here as we sit here.

A There is very little literature on the PEG technique that even mentions the safe track technique, except what I have written about it and what Dr. Foucth has written about it.

Q Do you agree with this statement, it is the responsibility of those performing PEG to keep

abreast of new developments and to adhere strictly to every detail of the technique?

A Did I write it?

Q You wrote it.

A Then I might agree with it. It sounded like something I had written.

Q Do you agree with this statement, the safe track technique has provided an excellent way of ensuring that there is no hollow viscus between the stomach and the abdominal wall?

A Yes. I use it routinely.

Q Ensuring is a fairly --

A It is a wonderful word.

Q --descriptive word, isn't it?

A It is a wonderful word. I have to say that nothing functions at 100 percent. And if there is a piece of bowel between the stomach and the abdominal wall that at that moment doesn't have air in it and most of the bowel doesn't have air in it all the time, for example, then you can theoretically go across that loop of bowel and not get air when you go in. So it is possible that the safe track technique can fail. That is an answer that I think is a very honest, scientific answer.

Q If we are to corroborate our feeling or belief and that is what it is, because you have not experienced otherwise, we can't find corroboration of that in the medical literature relating to PEG procedures, correct?

A That is a negative result. You are saying to me, can we corroborate that. We can go through airless bowel and do a PEG. I can't corroborate that. That is a hypothetical.

Q Let me say this, Doctor --

A Okay.

Q You have been advocating the safe track technique, Dr. Foucth has been a strong advocate of the safe track technique?

A He hasn't written any more about it, unfortunately.

Q Well, he has.

A Has he written more lately?

Q Yes.

A Good.

Q And I would ask you about that.

A Okay.

Q But assume that he has written and advocated the safe track technique.

A Okay.

Q If a recognized and respected endoscopist or surgeon is going to do a PEG procedure, uses a safe track technique and has a bowel perforation nevertheless, wouldn't you expect that that doctor would write an abstract or some type of response in the literature saying, look, this is being advocated, but even this isn't a guarantee that this complication is not going to occur?

MS. SANDACZ: Objection.

A Doctors rarely write up their complications unless they have a very unusual thing

Q Are you aware that Dr. Foucth has written recently in the literature, in the last three years, that this complication of bowel perforation can be completely avoided by use of the safe track technique?

A I wasn't aware that he had written the word completely, no, I am not familiar with that.

Q Are you aware that he has also advocated in the literature that the failure to complete the safety maneuver is an absolute contraindication to placement of a PEG?

A No, I wasn't aware that he had written that.

Q Do you agree with that?

A I would -- in my hands, that is true. But in

most of the world's hands, it is totally untrue. And most of the excellent endoscopists in the world, unfortunately -- and I brought this up before -- most of the excellent endoscopists in the world do not use that technique, although I think independently Greg Foucth, who I give all the credit, and myself, are trying to make sure that that becomes a part of'the PEG procedure. I think it should be.

Q And you are aware that Dr. Brown in his deposition, when asked to describe what his general practice is on performing PEGS, did not describe performing a safe track technique?

A That is right, right.

Q Do you know Dr. Brown?

A No.

Q Dg you know Dr. Vogten?

A No.

Q How did you come to be contacted in this case?

A I got a letter. [Indicating.]

Q Well, do you know how Ms. Sandacz became acquainted with you or knew of your availability to review a case like this?

A I have no idea.

Q Okay.

A I got a lot of cases about PEGS though that people called me about all the time, so--

Q Have you ever worked for Reminger & Reminger before?

A I am really trying to think. If I have, it has only been one time before, I think.

Q And I have to ask you this, because it leads to another question --

A Ask me, it's your dollar.

Q -- have you ever been sued before'?

MS. SANDACZ: Objection. Go ahead.

A Yes.

Q Here at the Cleveland Clinic?

A While I have been at the Cleveland Clinic?

Q Yes.

A No, not yet.

Q Are you aware that Reminger & Reminger is one of the law firms that frequently defends the Cleveland Clinic and its physicians here?

A I think I am. I think they use several law firms.

Q You are aware that Kaiser and the Cleveland Clinic have a business affiliation?

A Yes.

Q You are aware that the Ohio Permanente physicians affiliated with Kaiser are technically on staff here at the Cleveland Clinic?

A Yes.

Q Doctor, if someone like I contacted you a month ago or a month from now in the future and said, "Doctor, I have a potential plaintiff's case, it involves a PEG procedure, and it involves a PEG procedure put in by one of your colleagues either here at the Cleveland Clinic or at Kaiser," do you think you would have a conflict and you wouldn't be able to look at the case?

MS. SANDACZ: Objection as it relates to the Cleveland Clinic.

Q As an expert witness?

A If I didn't know the people here personally, I would look at the case.

Q You believe that you would be permitted to testify as an expert witness in a medical malpractice case against a colleague here at the Cleveland Clinic that you may not know?

A Let me phrase it this way, I wouldn't testify against a colleague at the Cleveland Clinic. A Kaiser Doctor that I did not know, and I am

being honest about it, I wouldn't want to testify against somebody that I knew and here at the place, but if it was a Kaiser Doctor and I didn't know him, I would testify against him, if I felt he was wrong. Yes, absolutely.

Q You have never written in the medical literature that bowel perforation is an unpreventable complication of a PEG procedure, have you?

A I have never written that any complication is unpreventable.

Q But you have written that you can ensure the absence of hollow viscus between the abdominal wall and the stomach by using the safe track technique, haven't you?

A When you say -- I don't think I have ever said you can prevent 100 percent. You can try to ensure. And I think if you look at what I have written, if you have anything there--

Q I do.

A I said if you try to ensure it by this. I never implied that it is a total prevention. There is no 100 percent prevention for any complication.

Q Read the last sentence in that paragraph. [Indicating.]

A The safe track technique originally described by

Foucth has provided an excellent way of ensuring that there is no hollow viscus between the stomach and the abdominal wall. And it is an excellent way, as I said before. However, it is not 100 percent successful.

Q Well, your use of the world ensure, is different than --

A It is a medical --

Q Pardon me?

A Well, I don' think that the word ensure means that there is 100 percent prevention.

Q Okay.

A We ensure that there is no polio in this county by giving polio vaccine but there is still cases of polio in this country.

Q Do you believe if Dr. Brown and Vogten had used the safe track technique there would have been a greater likelihood of prevention in Delmar Darrell?

A Yes, I do. Yes, I do.

Q What do *you* look for in **a** post PEG patient with regard to a possible intraperitoneal leakage?

A If I am considering intraperitoneal leakage, I do the injection of contrast medium immediately.

Q What are the signs and symptoms that you would

look for in a patient with intraperitoneal leakage?

A When we see patients with intraperitoneal leakage and we see quite a few for various reasons, the first thing they did get is abdominal pain and signs of peritonitis, fever, et cetera.

Q And I take it in a PEG patient, those types of symptoms give immediate concern for some type of gastric or colonic leakage?

A Yes.

Q All right. I take it that is something a physician can be vigilant about, following a PEG placement?

A Yes.

MR. HAWAL: If I can have a moment, I might be done. But I may have missed a lot of questions.

[Whereupon, a brief recess was taken.]

MR. HAWAL: Thanks. I am done.

THE WITNESS: Okay, thank you very much. Nice meeting you.

MR. HAWAL: Likewise.

THE WITNESS: I don't need to

read it. I will waive it.

MS. SANDACZ: You can send it to me.

- - - - -

CERTIFICATE

THE STATE OF OHIO,)
SS:
COUNTY OF 'CUYAHOGA.)

I, Robert J. Wanous, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, Jeffrey L. Ponsky, M.D., was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed on a computer/printer, and that the foregoing is a true and correct transcript of the testimony so given by him, as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 1ST day of November 1999.

Robert J. Wanous, Notary Public
within and for the State of Ohio
My Commission expires November 22, 2000.

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