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

IN THE COURT OF COMMON PLEAS

DOC. 363

ANTHONY P. DiMARCO, SR., et al.,)
)
Plaintiffs,)
)
vs.) Case No. 93862
)
LEONARD H. BERNSTEIN, M.D.,)
)
Defendant.)

- - -

Deposition of ARTHUR **PORTER**, M.D. a Witness herein, taken by the Plaintiffs as if upon **cross-examination** before Marguerite **A**, Sandly, RPR/CM and Notary Public within and for: the State of Ohio, **at** the office **of** Joseph L. Cotacchia Co., L.P.A., 1200 Engineers Building, Cleveland, Ohio, on Monday, the 28th day of April, 1986, commencing at 1:30 p.m., pursuant to notice and agreement of counsel.

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APPEARANCES:

Joseph L. Coticchia Co., L.P.A., by:
Joseph L. Coticchia, Esq.,

On behalf of the Plaintiffs.

Jacobson, Maynard, Tuschman 6 Kalur Co.,
L.P.A., by:
Dale L. Kwarciany, Esq.,

On behalf of the Defendant.

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that this deposition may be taken in stenotypy by Marguerite A. Sandly; that her stenotype notes may be subsequently transcribed in the absence of the witness; and that all requirements of the Ohio Rules of Civil Procedure with regard to notice of time and place of taking this deposition are waived.

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ARTHUR PORTER, M.D.,

a Witness herein, called by the Plaintiffs for the purpose of cross-examination as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposes and says as follows:

CROSS-EXAMINATION

BY MR. COTICCHIA:

Q. Would you please state your full name,

A. Arthur Porter.

Q. What is your address?

A. 11201 Shaker Boulevard, Suite No, 229, Cleveland, 44104.

Q. What is your date of birth?

A, 9-30-48.

Q. Are you married?

A. Yes.

Q. How long have you been married?

A. Ten years.

Q. What is your occupation or profession?

A. A urologist.

Q. Are you Board certified?

A. Yes.

Q. When did you become Board certified?

A. Two years after I finished, '76, 1976.

Q. In regard to this case in which Anthony DiMarco has made a claim for medical malpractice, what documents have you reviewed? And by that I mean medical records, written reports from other doctors, anything in the pleadings.

A. In preparation for this?

Q. Right. And tnat includes any literature, medical literature that you may have reviewed.

MR. KWARCIANY: Are you talking about in preparation for his deposition today or in preparation for his March 27, 1985 report?

MR. COTICCHIA: No, No. In regard to the deposition today,

MR. KWARCIANY: Okay.

A. The records from Marymount, the report of Dr. Proctor, of Schreibman, and of Katz. And also in terms of the literature, I called the company that makes Tobramycin and asked them to send any articles specifically targeted towards ototoxicity and aminoglycoside therapy, I also reviewed the Cambpell's Urology.

Q. Did you say --

MR. KWARCIANY: Cambpell's Urology.

Q. Textbook of urology,

Q. Khat company did you call in regard to Nebcin?

A. Eli Lilly Company.

Q. Were they the manufacturer of the drug that was administered to Mr. DiMarco?

A. It was them or one of their subsidiaries. I think Dista may distribute it. I am uncertain, but they're the one that has the largest medical library.

Q. Did you review the Physician's Desk Reference of 1983?

A. No, I did not.

Q. Did you know that there was a warning issued in regard to Nebcin in the Physician's Desk Reference in 1983?

A. Warning in terms of what?

Q. In terms of ototoxicity.

A. Yes, I am aware of ototoxicity.

Q. All right. But you were not aware that there was one specifically in regard to Nebein at least in the 1983 Desk Reference?

A. I am certain, as I have read the package insert from Nebcin and it's printed OR there, and that's the same thing. So I assume that it's also in there.

Q. When did you read the package insert?

A. I mean many times, Whenever I use the -- not whenever I use the drug, but in the past I've just read it,

Q. Well, was that something that you got when you called them or is that something you knew from experience?

A. I knew from experience.

Q. What kind of information did you get from Eli Lilly or any of their subsidiaries?

A. They sent a whale packet of articles from various investigators on ototoxicity and aminoglycosides as well as ototoxicity specifically towards Tobramycin.

Q. All right. It's my understanding that Tobramycin is an aminoglycoside, is that correct.?

A. Right. Correct.

Q. Before you prepared your letter, and my copy is blurred, is that March 21st?

A. I have it here. March 27th.

MR. KWARCIANY: 27th.

Q. March 27, 1985, Did you read the letter prepared by Dr. Proctor?

A. Yes.

Q. Is there anything in the literature that

you received from the manufacturer of Nebcin following your letter of March 27th?

A. No.

Q. That would --

A, All they -- all the literature I had was before then, I have not received anything since I wrote the letter.

Q. Oh, I'm sorry, All right. So there axe some statements -- are there statements in your letter which are based on the information you received from the manufacturer?

A. Yes.

Q. Okay, Would you tell me which statements they are?

A. I am not sure that they're specifically marked in here. I'll nave to go through this.

It was more that I used much of the, all the information in general to compile the report. I didn't take any dixect statements, just general information.

Q. I'm going to request, if you haven't brought those with you, that you --

A. I didn't, This is all I braught.

Q. -- through Mr. Kwarciany, that you provide me copies of that.

A. Sure.

Q. All right,

MR. KWARCIANY: They're not going to help you.

MR. COTICCHIA: I have enough trouble lust reading the warning.

THE WITNESS: I'll send you the articles,

A. Oh, I ain sure this came out, at the bottom of the second page of the letter, that was one of the articles that I read, but as I mentioned here, from the Journal of Infectious Disease by Neuton and Bendish, as far as the hearing loss was in question.

Q. Oh, yes. And who was the author you just quoted?

A. It's Neuton and Bendish. It's at the bottom of the page.

Q. I see it, That was in 1976, is that correct?

A. Right.

Q. The surgery took place in September of 1983, didn't it?

a. Yes.

Q. Did you discuss today, and I don't want

to know the content, but did you discuss today some of the questions and answers in regard to Dr. Bernstein's deposition?

A. Yes.

Q. Did you discuss them with Dr. Bernstein?

A. Nc.

Q. Did you discuss them with Mr. Kwarciany?

A. Yes.

Q. Is your medical malpractice insurance carrier PIE?

MR. KWARCIANY: Objection. You may answer,

A. *Yes.*

Q. Have you ever had occasion to sit on a review committee for PIE in regard to any medical claims?

A. No.

MR. KWARGIANY: Objection. You may answer.

Q. It's my understanding that you, prior to this lawsuit, knew Dr. Bernstein?

A. Correct.

Q. Is that correct?

a. Yes.

Q. To your recollection, how long have you

known Dr. Bernstein?

A. Ever since I did my medical training in the city and Dr. Bernstein attended conferences.

Q. "here did you have your medical training?

A. At Western Reserve.

Q. Was that your internship and residence?

A. *Yes.*

Q. When did you start your internship?

A. In 1974, and finished in 19, or finished the residency in 1979. Oh, wait. I said '76 for my Boards, I was wrong, it had to be '81; 1981. Bd Cert

I'm sorry. It was two years after I finished my residency.

Q. All right, And, of course, both you and Dr. Bernstein are urologists?

A. Right.

Q. You practice medicine in the same specialty?

A. Right.

Q. Sa you've known each other for approximately 12 years?

A. Right.

Q. Don't you think the fact that you and Dr. Bernstein being professionally acquainted for 12 years has some influence on your objective

analysis of the medical records?

A. No. I mean, we're not -- I mean, he's just in the same city. We don't -- I'm not friends with him socially or anything and don't work with him on cases, I mean --

Q. You both belong to the same medical associations, don't you?

A. I'm not certain what he belongs to. The American Urological Association, I would assume; Cleveland Urological, I assume he would belong to; and for the north central section of the country I would also assume he belongs; but those are pretty broad organizations.

Q. Don't you think that the fact that both you and he are insured by the same liability carrier would have some influence on your objective analysis of tho medical records in regard to this claim?

MR. KWARCIANY: Objection.

A. No. I mean, I didn't even know that when I reviewed the case anyhow.

Q. You didn't know what?

A. That he was, what insurance carrier he had.

Q. Who initially contacted yau in regard to

this claim?

A. I don't remember.

Q. It was an attorney from one of the --

A. It was an attorney. But what happened, it was sent by the attorney, I just got the phone call and they asked if I would review the case,,

Q. What attorney called you?

A. I don't remember. It may have been Hirshman. He was -- I don't know. I'm not certain,

Q. Don't you think the result of this case, just as a result of any medical. malpractice case, would have some affect on your own malpractice premiums?

MR. KWARCIANY: Objection.

A. No.

Q. I mean -- I mean, that really has no bearing in anything that I am saying.

Q. Had you found that there was a breach in the medical standard of care in regard to Dr. Bernstein's treatment of Mr. DiMarco, would you have written that opinion?

MR. KWARCIANY: Objection. If you would have asked him?

MR. COTICCHIA: No.

Q. Had you found in your analysis of the

medical records --

A. Would I have?

Q. -- a breach of the medical standard of care with regard to Dr. Bernstein's treatment of Mr. DiMarco, would you have put that in your written opinion?

A. Yes.

Q. Prior to preparing this report, did you first call any attorney from the offices of Jacobson, Maynard?

A. Prior to preparing the report?

Q. Right, before you wrote this letter to Mr. Hirshman.

A, I don't -- I'd say no, but I don't -- I mean, I don't remember calling anybody.

Q. You didn't have a confexence with him before you prepared this letter OK with any attorney?

A. The first thing I remember is just writing the letter in response to the, to the letter they haa sent or the communication they had sent with the chart and the letter and, you know, from Proctor and that stuff.

Q. What does the abbreviation BUN mean?

A. Blood urea nitrogen.

Q. And what is that a test for --

A. That's one of the tests for renal function.

Q. What does renal function refer to?

A. It refers to the ability of the kidneys or kidney to purify the blood.

Q. What were the results of those tests in regard to Mr. DiMarco's admission at Marymount?

A. I don't -- if you have a copy of the report, I am sure I could find it.

There is one from 9-1-1983 where it's 13.

Q. Can I see what you're referring to?

MR. KWAKCIANY: He is referring to the admission test on 9-1-83.

Q. I have it here,

A. Right here, (indicating).

Q. Okay.

MR. KWARCIANY: Are you asking him about subsequent BUNs and creatinines that were taken?

A. This is the first one.

Q. That was the first one.

Dr. Porter, is there anything significant in regard to, I guess we're referring to the Marymount Hospital, Garfield Heights, hospital

record at the bottom where it says, DiMarco, Anthony, lab number 39, I guess that's a good identification?

MR. KWARCIANY: Why don't you give it by date:, too, September 1st of 1983.

MR. COTICCHIA: Right, All right.

Q. Is there anything significant in these findings?

A, No, The BUN, and even far more importantly, the creatinine are both normal,

MR. KWARCIANY; That was before Tobramycin was administered.

A. The creatinine is here, right here.

Q. Khat is creatinine?

A. Creatinine, again, is one of the by-products again in the blood, again used to help evaluate renal function, but is considered a more accurate assessment than is BUN by itself.

Q. All right. There were several other tests done. I would imagine my chart and your chart follow the same sequence. Does the next page show September 1st blood bank record?

A. No. Wait.

Q. Right at the top.

A. On, yes, right at the top.

Q. The next one is hematology test?

A. Right.

Q. And the third one is a urinalysis?

A. Urinalysis, right.

Q. With regard to the first one, blood bank, or Roman numeral one, what kind of a test is that?

A. It's just in case -- that's a blood type and screening in case he needs blooa during surgery,

Q. Anything unusual or abnormal in that record?

A. No.

Q. In regard to the hematology, the next test record --

A, Again, these are tests for blood; and they're normal,

Q. And in regard to the urinalysis?

A. The urine shows, it is essentially normal except for zero to one red cells or white cells in the urine,

Q. Now, that was prior to surgery, is that correct?

a. Right.

Q. Let's go on to the next page,

Again, this is a report from hematology,

the date I have is 9-1, what kind of a test is this?

A. Again, it's a test. of some of the red cell parameters as well as platelets and white count. Again, that's normal,

Q. Then we have underneath that A chemistry to phosphatase, what is the purpose of that test?

A. The acid phosphatase test is one of the blood tests that we use to look for carcinoma of the prostate.

Q. What were the results of that test?

a. It was within the normal range of .42.

Q. Do you see carcinoma, is that what I understand as a layman to be cancer?

A. Yes, right.

Q. And that came back normal?

A. (Indicating.)

MR. KWARCIANY: You have to answer verbally.

A. Right, yes,

Q. All right. Let's go to the next page. This is from microbiology. What kind of a test is this?

A. Again, it's -- wait, Is this --

MR. KWARCIANY: You're referring

to the --

Q. 9-2-83.

A. These are further blood studies; again showing BUM, creatinine and electrolytes,

Q. And that test came back normal?

A. Normal.

Q. There is on the bottom, no growth at 24 hours, there's a note from the lab.

MR. KWARCIANY: You're on the bottom, I was looking at the top one. You're looking at the bottom one?

Q. I'm sorry. My copies are out of sequence,

A. Okay. All right. This one you're talking about is the microbiology test, correct, it states no growth.

Q. All right. Then we have -- what I will do for the record, I will refer to the bottom of the test form so at least we have a starting point for the purpose of the test.

What -- again, referring to microbiology, what kind of a test is that?

A. They take a sample of urine, put it in an agar plate or some sort of culture medium and see what kind of bacteria grow.

Q. And after 34 hours this test indicates

that there was no presence of bacteria?

A. That there was no growth.

Q. Which means that there is no infection?

A. Which means on that plate that there was no growth,

Q. All right, I want to go on then to the next one on my list, which is captioned at the bottom chemistry.

A. On the same sheet?

Q. On the same sheet,

A. Okay.

Q. It's dated September 2nd and it's got --

A. Wait. September 2nd?

Q. 9-2-83?

A. This one's 9-4, chemistry. That must be this page. Now, which urinalysis? There is a urinalysis on the page you're now talking about, on the same page there is no growth; that does show bacteria in the urine as well as a few white cells and an occasional red cell.

Q. What is the date of that?

A. That's dated May -- 9-2, with urinalysis.

Q. Does that have lab number 24 on it?

You see lab, (indicating)?

A. Lab number 26.

Q. All right. And there is a -- okay. It says --

A. The urine --

Q. -- color and appearance, specific gravity?

A. This is now changed. I mean the color is still yellow, the appearance now is cloudy, which again may mean that there is some bacteria or something that's different, because the last one was clear.

Q. Could that also be aue to blood?

A. Can be due to blood.

Q. All right.

A. And there was some blood, although under microscopic examination there was no change in the amount of blood, but there were more bacteria there, I mean, there were more white cells,

Q. More bacteria, is that WBC, RBC?

A. Right here, white cells. Now it's zero to three, before it was zero to one. Here bacteria shows a few bacteria in the urine.

Q. A few. All right.

Is that an indication of a dangerous infection?

A. It may be. I mean, it's not -- no, just to have bacteria in the urine is not a dangerous

infection, It Just means there is bacteria in the urine.

Q. This essentially is a normal result?

A. No. You can't really call it normal if there is bacteria and white cells in there,

Q. Okay. All right. My question is, and I want your opinion based upon a reasonable degree of medical certainty, is thexe, in and of itself, an indication of sepsis, of infection?

a. From this urinalysis?

Q. Yes.

A. No.

Q. Now, in regard to the report -- I guess what I'm referring to on the dates is in the upper right-hand corner and that it will say date drawn, which is usually the next day, there is *a* chemistry report, date requested September 2nd, 1983, date drawn September 9, '83?

A. September 9, or September 3?

MR. KWARCIANY: It says September 3rd.

Q. I beg your pardon, My copy doesn't look good, You're right, it's September 3rd. A11 right. And then it has X's in front of the box creatinine, BUN, Chloride, C02.

A. Right.

Q. Is there anything unusual or abnormal in those results?

A. No. Your sodium is slightly low, but that's not significant,

Q. That is essentially a normal result, isn't it?

A. Right.

Q. I guess we're on different pages, Doctor, but I am referring now to a chemistry test result, again date requested September 3rd, date drawn, and date recorded September 4th, it's the same test?

A. Lab number 23.

Q. Lab number 23, yes.

A. Right. Okay,

Q. Again, is this result essentially normal?

A. Yes.

Q. Now, we have a serology report. This is dated September 1st, and the blood was drawn September 1st?

A. Right.

Q. Anything abnormal here?

A. No.

Q. And the next one I have is from microbiology, By the way, where it says serology -- let me back

up a little bit..

A. Serology.

Q. What did I say, seriology?

Serology, does that pertain to blood?

a. That's blood.

Q. All right. And then we go to microbiology. This again is a urine test, isn't it?

A. I think this is the one we went over already,

MR. KWARCIANY: That's the first urinalysis we went over.

A. The urine culture that shows no growth.

Q. All right. We went over that. Now I've got -- my pages are out of sequence. I have a September 2nd hematology, which I believe was on a different page from yours,

A. September 2nd, lab number what, 10?

9. Yes.

A. Okay.

a. Did we talk about: that?

A. No. We talked about the hematology one from before.

Q. All right. This is lab number 10. This is a blood test, isn't it?

A. Correct.

Q. What do they test for?

A. This is looking at your number of white cells, your number of red cells and various parameters for those particular cells as well as your platelets.

Q. What's the purpose of the test?

A. You want to know how much blood, the volume of blood cells in the person and whether there is -- you're also looking at the white cell response as well as your platelet response.

Q. What are the results in regard to this test?

A. It shows several things. First of all, the white count is slightly up at 11,000. And your hematocrit is now 36.6, which has dropped from your prior hematocrit. The remainder are within, you know, acceptable range.

This also, incidentally, shows a slight increase in the bands, Band cells is a response of the bone marrow to make more white cells, which is a response to stress, again meaning sepsis, or some other sort of stress. And the number of bands is up.

Q. Does this test establish, within a reasonable degree of medical certainty, that

Mr. DiMarco had an infection in his

A. Not in and of itself. Again, you know, you are not going to just rely on any one particular test by and of itself to document sepsis.

Q. All right, Going on to the hematology dated September 6th, and the date drawn is September 6th. Again, I notice that the white blood cell count is up?

A. Even further.

Q. All right, However, underneath where it says differential, and I don't understand this, a lot of the numbers are less?

A. Right. Those are percentages, this differential. And it's a shift around, that's what's happened. You see an increase in the lymphocytes, and where there's an increase in the lymphocytes, those are types of white cells, And, as I say, it's a percentage, so they add them.

Q. What does it mean when the WBC has gone down from 73 to 67?

A. Segs are one of the cells which fight infection, Leukocytes are another one that fight infection. It just means there's an increase in the lymphocytes and a slight decrease in your seg matter.

Q. Well, you pointed out in the other one that the bands is 10, now the bands is 4; what does that mean?

A. The band is an acute, is an acute response to making of new blood cells, The band cells are the immature forms that come out into the periphery before they really begin to he mature white cells. And that's what we're dealing with.

Q. Is there something here that Dr. Bernstein should have been alerted to in regard to the decrease in these numbers?

A. No. A contradistinction, I think, probably is the increase. The further increase in the white blood cell count would alert you to the fact that you're probably dealing with some sort of infectious process,

Q. Infectious what?

MR. KWARCIANY: Process.

A. Process.

Q. Process.

Looking at the report from September 6th with the increase in white blood cells to 15.7 --

A. Yes.

VI -- that is an indication, isn't it, that there may be infection in the blood?

A. Or infection anywhere. Right,

Q. Anywhere, being carried by the blood?

A. It's just monitoring the blood,

Q. All right. But based on all the other tests in conjunction with the urinalysis and the other -- I don't know what you used as the term chemical --

A. Xes, The chemical. Now~so far we have a urinalysis which showed a few bacteria, The urinalysis also showed an increase in the white cell count, And now we have a rising wnitc count and we know we had a shift, we had an increased bands from the chemistry, or hematology.

Q. Well, on the urine we know we went from zero to three on a white blood count, but I think your testimony was that that was still within normal range?

A. No, I said it's not. You have no bacteria on the initial one, you have some bacterium, you have only zero tu one white cell in the beginning and it goes to zero to three. That's not great numbers. You can get 15, 20 white cells, But to see some bacteria means, you know, you start to look out, start to be aware, stawt to prepare yourself that you may have some problems.

Q. I see. I must have missed something. Where was the indication of bacteria?

A. It said on the --

Q. It says few.

A, -- on the page before, few bacteria, That's just a microscopic thing, taking one drop of urine and seeing some bacterium. And that's also several days earlier, and these bacterium in any kind of medium can increase in numbers.

Q. All. right. If I have a blood test and I have a urine test, all right, and if my -- and I feel good today, all right -- and I have a urine test and it comes back, under bacteria it says few, what does that tell. you as a doctor?

A. Well, you can't judge just on laboratory studies, you have to go along with the clinical symptoms and a clinical physical examination,

Q. So it could mean anything, isn't that correct?

A. It's not that it could mean anything.

Q. You could have a bad cold?

A. You wouldn't get bacterium in the urine from a bad cold,

Q. I wouldn't?

a, No. Bacterium in the urine means that

the bacterium is there far some reason. A cold is a virus, these are bacteria, that's different.

Q. Yes. I -- well, I am not going to get into colds being a virus. I mean, there are other types of colds, aren't there, you can get a cold having a bacteria-type cold, can't you; chest colds, chest infection?

A. Again, you're talking something different.

Q. All right,

A. If it's in your chest, it's in your chest,

Q. Yes.

A. If it's in your urine, it's; in the urine. That's -- I mean that's --

Q. What I'm getting at, it's not unusual far somebody like Mr. DiMarco following prostate surgery, a prostatectomy, for the doctor to order an antibiotic, right?

A. To order an antibiotic, no.

Q. That's a common medical standard, isn't it?

A. Right.

Q. The issue here is not that, but the use in addition to Kefzol of 25 ok 26 injections of Nebcin --

A. Right.

Q. -- during this man's admission?

A. Right.

Q. And the Nebcin wasn't really administered until after surgery?

A. Correct.

Q. Ana it wasn't administered until after the Kefzol was administered?

A. Right.

Q. Now, my question to you is, first of all, number one, we have no clear-cut sign in the urinalysis, do we, of sepsis or infection?

A, You are not -- you can't have a clear-cut sign of sepsis. Sepsis can be from -- I mean, yau have to put the, as I mentioned to you just before, the whole clinical situation together. Ne has a rising white cell count, he has an elevated bands, he had bacteria in the urine which were not there initially. On the initial admission to the hospital from 9-1 there were no bacteria. Subsequently he did have bacteria, so these things lead you to think about infection. Then an the night before the Nebcin was started there'a a note in the nurses' nates talking about chilling and feeling cold. Again, that's one of the key indicators, again, not by itself, but put together

in the whole clinical situation where you've gut to think about sepsis, blood stream infection, you still have a foreign body and you have the other surgical procedures.

Q. I don't think our expert has any disagreement with that. As a matter of fact, the note in regard to Mr. DiMarco complaining about that he felt chilly also indicated that, I think, his temperature was 98, or it was not, and in Dr. Bernstein's own testimony, was not a spiked fever, was it?

A. No. Usually with sepsis you feel cold well before the fact, and shaking chills well before the fact that you have the -- in terms of the time sequence -- before you have the rise in the temperature.

Q. Your fetter didn't give any mention of that, did it?

A. No.

Q. As a matter of fact, that's something you just learned today, based on Dr. Bernstein's testimony, is it?

A. Yes.

Q. Isn't a fever a more reliable indication, and I don't mean a low-grade fever, I mean a spiked

fever?

A. Right, A spiked fever is more reliable,

Q. and Mr. DiMarco did not have one, did he?

A. Did not have a spiked fever?

Q. Is that correct?

A. That's correct.

Q. Now, couldn't Dr. Bernstein, in light of these indications that you've mentioned, have increased the dosage of the Kefzol?

A. I'm sure he could have increased the dosage, but the Kefzol was started in an appropriate dosage and he was on Kefzol, and generally when patients start to have signs or symptoms of sepsis, you go to an additional drug, an additional medication that can cover other gram-nega bacteria, which is what we're concerned about here,

Q. So it's your testimony that the dosage of Kefzol. was already in the recommended maximum?

A. Not recommended maximum, it was within therapeutic dosages; and the dosages in the urine are far higher than dosages elsewhere, it's concentrated in the urine.

Q. How was the Kefzol administered?

A. Kefzol was intravenous,

Q. Couldn't he have increased the frequency

of the dosages?

A. Yes, you're right, you can change the dosages. But whst I am saying, when you're concerned about sepsis, you go to an additional medication, sometimes even three other medications.

Q. All right, When did Dr. Bernstein put Mr. DiMarco on Kefzol?

A. Right at surgery.

Q. All right. And how long, how many days was he on Kefzol?

A. It was about four. You mean until he started the Tobramycin?

Q. Right,

A. Four.

Q. How long after surgery aid Dr. Bernstein start the Nebcin?

A. Four days.

Q. And there is nothing in the record, is there, where Dr. Bernstein either by application or dosage increased the use of Kefzol; he simply continued in the same regimen with Kefzol and in addition ordered injections of Nebcin?

A. Right.

Q. Is it your testimony th'at under those circumstances that's within the standard of medical

care?

A. Yes.

Q. In fact, there was no blood culture to determine bacteria, was there?

A. No, there was not.:,"

Q. And that test was available at Marymount at the time of Mr. DiMarco's admission, wasn't it?

A. Right,

Q. Isn't that something he should have done before he decided to apply or administer Nebcin?

A. It's something that you could have dons concurrent with, I mean, he couldn't wait fow the results of the blood culture. And a single blood; culture in and of itself is not significant unless it's positive, But he may have infection in the blood and have negative blood cultures, if it's, especially if it's seeping from the abdomen at or near a small focal point. You only get a positive blood culture if it's seeping out from there,

Q. My point is, that could have been done right there at the hospital, couldn't it?

A. Yes.

Q. And if a doctor has a patient in recovery or intensive care following prostatectomy surgery calfs the lab and says, I'm concerned about

infection --

A. No.

Q. -- can't you get it promptly instead of having --

A, It's a biologic test, it's not --

Q. How long does it take --

A. It takes at least 24 hours.

Q. -- to get that?

A. Sometimes you can start to know there's a reading 12 or 14 hours later.

Q. Is it your testimony that this risk was so great that Dr. Bernstein couldn't wait 24 hours before --

A. Yes.

Q. -- administering the Nebcin?

A. Yes.

Q. What is the basis of that opinion?

A. If the patient had true sepsis, then he could die,

Q. I agree. Shouldn't the doctor, shouldn't Dr. Bernstein have started the blood culture test right along with the urinalysis and the hematology?

a. You mean from the early one?

Q. Right.

A. No, The blood culture is a test you get

in response from certain clinical indications. And you may get that, but still you have to proceed with what's clinically indicated,

Q. In other words, it's not within the standard of care far a doctor to do a blood culture immediately before and immediately after surgery, a prostatectomy?

A. No.

Q. When he's passing blood, and when you say as these indications may be that there may be sepsis --

A, I, mean, as I: say --

Q. that's your testimony, that's not within the standard of care to do that?

A. Right. I think to get a blood test is appropriate after he started to suspect sepsis,

Q. When did you start to suspect sepsis?

A. I mean, several days after surgery, At that point it's routine or acceptable to get a blood culture.

Q. As a matter of fact, the Kefzol was used for that reason, wasn't it?

MR. KWARCIANY: Objection.

Q. The application of Kefzol?

a. Was used to prevent infection.

Q. Right,

A. Right.

Q. That was the reason for it, wasn't it?

A. Right.

Q. It's a broad-spectrum antibiotic, isn't it?

A, Right.

Q. The problem with Nebcin -- let me restate that.

The risk with Nebein is ototoxicity, isn't it?

A. As well as nephrotoxicity.

Q. Right. And in this case we know Mr. DiMarco's lasyrinths had been destroyed?

A, Wait. Right, you mean ahead --

Q. Today,

A. Today.

Q. Today, following the application of Nebcin, isn't that correct?

A. I'm not sure they've been destroyed, but they have been injured,

Q. Did you read Dr. Kats' report?

A. Yes, But if you're going to ask me a question, I just would like to look at it again. I read it a while back.

Q. You read Dr. Schreibman's report, too?

A. Right.

Q. And it came back positive that he had no function in the labyrinths bilaterally; you remember reading that, is that correct?

A. Right. I was thinking it was partially damaged. I don't remember the report,

Q. In regard to what was previously marked Plaintiff's Exhibit 3, which is Dr. Katz' letter of October 2nd, 1985, I will quote you the second paragraph. "Mr. DiMarco has the absence of vestibular function bilaterally, This appears to be the result of the Tobramycin received," Do you agree or disagree with Dr. Katz' conclusion?

A. I'd -- I mean, I agree. You mean was it presumably from the Tobsamycin?

Q. Yes.

A. I agree,

Q. Okay, Doesn't Dr. Bernstein, under these circumstances, have an obligation to discuss with Mr. DiMarco the risk of ototoxicity in the application of Nebcin?

A. I am not -- no, I don't really think so. The risk of ototoxicity is quite, is quite small and I think it would be a greater risk if he would,

in the normal range, scare a patient out of using a drug that could potentially help him with sepsis. And if the patient then became septic, I think those risks would be far greater than the risk of ototoxicity.

Q. Isn't it a fact that based on all the hematology and urinalysis tests and these lab reports -- and we haven't gone through all of them, but I assume you dia prior to today, did you not?

A. Yes.

Q. Based on all these tests, chemistry, hematology, urinalysis, blood, there is nothing to indicate within a reasonable degree of medical certainty the presence of bacteria, is there?

A. No. There were tests to indicate that. As I say, the urinalysis did show it and the blood studies showed changes consistent with some infection in the body,

&a The urinalysis showed from zero to --

A. To one; to a few bacteria.

the white blood cell count?

A. Several of then did actually.

Q. nli right.. But some of the other counts went aown, didn't they?

A. You're talking about your different counts, your differential counts, and those --

Q. All right. Let's continue with those, Where did we stop here, September?

A. 7th.

Q. We have September 6th, we have hematology, we talked about that. Now we have September 7th hematology, An3 this comes hack with MCT; what does that mean?

A. That's the hematocrit, which is a function of how many blood cells tnere are,

Q. All right. And it reads 29.0, what does that mean?

A. It means the percentage of red cells into the blood is 29 percent, which is low and is usually meant to be an indication of that there is a need for a transfusion.

Q. The need for transfusion, all right.

And that's because he was passing blood, of course?

A. Right.

Q. All right. The next page in my records

shows September 3rd and September 4th. What does yours show?

A. Wait. I have a September -- yes.

Q. September 5th, there is also a test, a hematology test, where it says Monday on the side?

A. Yes.

Q. Okay, Is there anything abnormal in that result.

MR. KWARCIANY: Which one now are we talking about?

A. Which one?

Q. In regard to September 3rd.

MR. KWARCIANY: You're talking about the September 3rd chemistry?

A. Lab number 27, right, Lab number 27 is normal, Lab number 10 -- there are several of these numbers that have repeated themselves, I don't know if it makes any difference.

Q. Yes.

A. Okay. Lab number 10 from 9-5 shows, again, a minimal elevation of the white cell count and a decrease in the hematocrit, Platelets are normal, And your differential is okay.

Q. Considering the patient has just undergone prostate surgery, or a prostatectomy, is

there anything unusual in these tests?

A. On the 5th?

MR. KWARCIANY: Which test are you talking about?

A. This page that we went through,

Q. All three of these, the chemistry and the two from the hematology?

A. No, other than the drop in the hematocrit,

Q. What is the hematocrit?

A. It's 36, and he came in at 42 I think it was.

Q. What does hematocrit mean?

A. That's the percentage of red cells in the blood.

Q. All right. Let's go on. The next one I have is a blood bank.

A. Pes.

Q. Ana it says, patient antibody screen. By the way, the date is very vague, it looks Pike September 7th.

It says patient antibody screen negative?

A. Right.

Q. What does that mean?

A. Those are blood bank tests so that they properly crossmatch the patient so he doesn't have

a transfusion reaction,

Q. A transfusion what?

A. Reaction. When he gets -- this is if he has to get blood, They send it, a sample down, they want to test this so they can give him the appropriate blood.

Q. And that test came back negative?

A. Right,

Q. Patient antibody screen negative, that means no infection in the blood?

MR. KWARCIANY: Objection.

A. That's purely for screening bloods.;

Q. What is antibody screen?

A, They're just looking for -- you form antibodies from prior transfusions, If you have a minor transfusion reaction one time, your body develops antibodies, because it's a foreign protein, and when these become strong enough or different enough, you have to eliminate or do certain specific things to the blood before you can transfuse it, That has nothing to do --

Q. I am confused, Did they take a sample of Nr. DiMarco's blood?

A. Yes.

Q. Is this the chart based on the sample

they took?

A. Right. Yes.

Q. What do they do with that sample?

A. This has nothing do to with infection. If you were tested or any other person is tested, there is a certain number of tests that you have to go through in order to make sure that the blood that you're ta be transfused with is properly matched, and they look for certain antibodies.

Q. I guess I understand that. I guess my question is, why do they have this section in here for patient antibody screen?

A. Because they're looking for reactions in the blood from old transfusions for foreign protein, a reaction to foreign protein.

It's similar to these things down here, See where it says Coombs test, down right below that where you're looking, those are all antibodies that you're looking to test,

Q. Yes. And those are all marked down okay?

A. Okay. That's what they're looking for, that sort of thing, But there is a whole group of minor antibodies as well that you look for.

Q. And there is another one, tested and found nonreactive for hepatitis antigen and

syphilis serology.

A. Right.

Q. All right. We have the next test which is hematology, September 6th.

Now, when did you say that Dr. Bernstein started administering Nebcin?

A. On the 6th.

Q. If you don't know, you don't know, but do you know from the record whether this test was done before or after?

A. It says here it came back, it was ordered on the 6th and came back on the 7th. At the top of the thing is the time.

Q. Yes.

A. So it couldn't have been there, this was after the Nebcin was administered.

Q. It was.

A. It got back to the chart, I mean.

It was ordered the 6th, it was drawn on the 7th and got back to the chart, I presume, some time on the 7th.

Q. All right.

A. Oh, here it says it was drawn at 6:50 and reported at 10:10 on the 7th. That's after, that's 24 hours after the Nebcin was done. And

significantly here you see, as we were talking before, the decrease back down in your white cell count.

Q. All right. Now, isn't it a fact that the proper dosage or administration of Nebcin really should not nave gone on for a couple of days?

A. No.

Q. In light of the fact that now, as you've pointed out, the white blood cell count had gone down to almost normal range?

A. No.

Q. To one point --

A. No. The white cell count will come down or may come down before the infection is really cleared up, If they were having an abscess transmitted or some infection that got into the prostate tissue from the rectum, especially in a small area, it was receeding, you have now cleaned the blood, the white count is coming down to normal, but the infection is certainly not clear ana you've gut to use a therapeutic dosage, I mean a therapeutic length of time to get rid of it.

Q. Now, you mentioned bacteria from the rectum, There was a biopsy, wasn't there?

A. Yes.

Q. That was -- where was the biopsy done, what part of the anatomy?

A. Transrectal biopsy.

Q. It's common, isn't there, to find flora in that area in any person?

A. Yes.

Q. I have it today, don't I?

A. Yes.

Q. We have it in our mouths, too, don't we?

A. Different flora, presumably.

Q. And we have it in our intestines, too?

A. Right. Correct.

Q. Are you testifying that this could have caused infection?

A. The flora in the rectum?

Q. Yes.

A. Yes.

Q. Just with a needle biopsy?

A. Yes. It's a known risk of prostate biopsies that there is an increase risk of sepsis from that.

Q. My question is, is it your opinion within a reasonable medical certainty that it was necessary in light of the dropping in these ranges, in the blooa tests, and in light of the fact that

there was no serum culture --

MR. KWARCIANY: what, Counsel?

MR. COTICCHIA: Blood cultune.

Q. -- blood culture, and in light oS the fact that there was no blood test to determine the presence and the so-called peaks ana troughs of the Tobramycin in the blood, was it necessary for this patient to undergo 25 injections of Tobramycin?

A, First of all, there is something -- I think the blood culture could be used for two reasons, One is to question whether you have an infection. Number two is to find the appropriate antibiotic to treat it, I think in this case, if you were using a blood culture, it would not be to say, do I have an infection in the blood stream, because I think you can assume that from this medical history. You would be using a blood culture to say, what is the appropriate medication to treat that infection.

With the lowering of the white count from 96 to 97 (sic) and the general improvement in the clinical situation, I think that the practitioner's faced with saying, he's getting better at this point, I've done the right thing for him.

Q. It seems to me -- what was the date of

the discharge here?

MR. KWARCIANY: 15th.

Q. (BY MR. COTICCHIA) so we've got approximately, starting on the 6th, we have got eight, almost nine days with approximately three injections per day of Nebcin?

A. Right,

Q. Is that correct?

A. Correct.

Q. Commensurate with the use of Kefzol, correct?

A. Yes.

Q. Don't you think it would have been safer after three days to take, in light of the risk the patient runs of ototoxicity, after three days of the Nebcin, wouldn't it have been safer just to stop or suspend that therapy?

A. No. No. When you start therapy like that for presumed sepsis, especially, as I say, in light of the fact that. he's had a transrectal biopsy, he has a foreign body in terms, forms of a catheter in his bladder, he has blood clots, and you know that he had bacterium in the urine early on, you got to use it for a therapeutic length, and that's seven to ten days of the Nebcin.

You have not gotten to any BUN and creatinine, and renal function, and this was done and it was normal the entire time. If the renal function started to change, then you'd be appropriate in, not so much stopping it, but leaning out your dosage, adjusting your time frame.

Q. However, in light of the risk, Dr. Bernstein should also have done, should he not, a blood test to determine the levels of Tobramycin?

MR. KWARCIANY: We're talking peak and trough levels?

A. You're talking peak and troughs?

Q. Right.

A. *Yes*. That's not useful in a clinical situation, It's not used, It's more useful in special situations, if you've got to use aminoglycosides with severely compromised renal function, if you got an aminoglycoside in a patient with a severe problem, if he's very old, if a patient is very obese, you know, these things, where you want to be certain of your level, you may use a peak and trough level one or two times. But in a routine patient with normal renal function, peak and trough levels are not used in a clinical situation.

Q. All right. Do you agree with Dr. Proctor's statement that aminoglycoside antibiotics have a very low therapeutic index:"

A. Yes.

Q. They cause toxicity at serum levels only slightly above the bactericidal levels?

A. Correct.

Q. Do you agree with Dr. Proctor where he states that there was no evidence that Mr. DiMarco had any infectious process which required the use of an aminoglycoside?

A. No, I don't. I don't think he carefully looked at the records or missed these clinical parameters. I think that's important, You know, Dr. Proctor is not a clinician ana is not faced with these decisions. I mean, it's very different when you're sitting in a laboratory to try to determine theoretically how to use a drug or whether you're faced in a clinical situation where you don't use it a patient can die or be severely ill as opposed to using it.

Q. Is it your testimony that Mr. DiMarco was dying?

A. No, But Mr. DiMarco could well have died had appropriate medication not have been,

appropriate treatment not be instituted at that time.

Q. Our bodies manufacture certain agents to fight bacteria, don't they?

A. They do,

Q. If I had zero to three or few bacteria in my urine today and everything else in me is normal, what would you advise?

A. Again --

Q. Are you going to administer an aminoglycoside?

MR. KWARCIANY: Objection.

A. That's not what the clinical picture presented in Mr. DiMarco's case on September 6th of 1983. And you're distorting it, Mr. Coticchia,

This is -- remember, this is a man who is in his mid ~0s ,who had a transrectal biopsy, who had bacterium introduced, this is an acute change from none to a few, this is a man who had blood ciats in his bladder.

Q. None to few is not acute, is it?

A. Acute change. Acute change.

Q. That's what I am saying, it's not an acute change?

A, It is an acute change, he has a rising

white count, he has a foreign body in his urine, in his bladder.

He's not a, quote, healthy man, no. If he came in, or if somebody just has a few bacterium in his urine, you don't use an aminoglycoside, hut you do use other medications at that point.

Q. The second page, second last paragraph of your letter states that, going down midway, right on the margin, there are appropriate indicators as to when the dosage should be cut back. However, this patient did not have any of these predisposing factors. These include a long duration of clinical therapy. Now, what do you mean by a long duration of clinical therapy?

A. It says, if that sentence continues, meaning more than ten days diuretic use.

Q. Wait a minute. More than ten days of what?

A. Of an aminoglycoside. That is considered a long duration of therapy. We had it less than that. And that's where you're talking therapeutic index again.

Q. That's my question. We have going along in this system intravenously -- and I assume that's 24 hours a day?

A. Right.

Us -- Kefzol?

A. Right.

Q. Correct?

A. Right.

Q. Therefore, why is it necessary to give Nebcin three times a day when normally this would be given without the necessity of Kefzol; why both, isn't that excessive?

A. No, It's not excessive, and that's -- I mean no.

Q. It's not excessive even though we got a minimum, we go from zero to a few or three bacteria in the urine. We don't have a culture in regard to any growth OK bacteria, And we have after a day or two, as you have testified, a significant drop in the white blood cell count, Yet you think, it's your testimony that it's necessary to continue three injections a day for eight or nine days of Nebcin?

A. Right. As a physician looking at this and interpreting this data, again, you're saying, here's a patient getting sicker, you use a different therapy, you add to your medication, he's not getting better, he's improving, and that's what

you got to go with, If you stopped and then he gat sick again, you're in a worse situation.

Q. If he got sick again, yes, but the only way you'd know that is to stop and check the blood and do the tests again, isn't that correct? Wouldn't that have been safer than running the risk of destroying the labyrinths?

A. No. As I mentioned to you, the labyrinthine changes is extremely unfortunate, but it's a very rare complication. And the risk of infection is quite, quite high. And you've got to deal with that in a practical manner.

Q. Now, you didn't mention the labyrinthine damage, you mentioned hearing loss at the bottom of page two, the last paragraph, isn't that correct?

A. Wait. Right. Yes.

Q. The first sentence, last paragraph, page two.

A. Right.

Q. At the time you wrote this letter, was it your impression that he suffered the hearing loss as a result of the Nebcin?

A. The hearing loss?

Q. Yes.

A. No. He had hearing loss prior to, from a

past tinnitus media or so.

Q. Your letter says, as far as the hearing loss, this is certainly an unfortunate aspect, however, Tobramycin has the least ototoxicity of all the aminoglycosides?

A. That should have been labyrinthine damage.

Q. So you were under the impression that he lost his hearing?

A. No. No, I knew that. It was just when I proofread the letter.

Q. It was an oversight?

A. It was an oversight on my part. It should have been labyrinthine damage.

Q. That was something you missed in your proofresding?

A. Yes.

Q. Is the inability to obtain an erection a risk of prostatectomy surgery?

A, It is a risk. It's noted in every, in the preoperative teachings of all transurethral resections, we don't know the cause of why, we just know approximately 10 percent of men claim to have impotence after surgery.

Q. Isn't this a risk that should be discussed with the patient?

A. I mean *yes*,

Q. Particularly in light of the fact that Dr. Bernstein said that at least they were satisfied prior to surgery that the indication was that Mr. DiMarco did not have cancer?

A. Wait a minute.

MR. KWARCIANY: Objection. Say that again.

(Notary read back as requested.)

MR. KWARCIANY: I will object to that, because I don't ever remember that statement being made during Dr. Bernstein's deposition.

Q. (BY MR. COTICCHIA) Assume that it was, assume that the initial pre-admission physical and the test at least indicated that Mr. DiMarco did not have cancer.

A, Okay.

Q. All right.

A. The surgery for prostate cancer is virtually 100 percent causing of impotence. The surgery for benign prostate is approximately 10 percent.

Q. And this is a risk?

a. This is -- benign gland. Presumably, I mean, he was concerned, he took the prostate biopsy

assuming that it was, that he went ahead and did a transurethral resection. The risk of that is one in ten.

Q. And that's something that should be discussed with a patient by the doctor, isn't it?

A. I would think so.

Q. But we don't know, or do you know whether his inability to obtain an erection is due to the normal risk following prostatectomy and/or due to the destruction of the labyrinths which creates an inability to maintain balance?

A. No, it has nothing to do with the -- first of all, I don't know that he is impotent.

Q. One of his complaints is that.

A. It has nothing to do with the aminoglycoside at all.

Q. The loss of balance and the inability to maintain steady disposition does not affect a person sexually or an ability to get an erection?

A. I mean no.

Q. That's your opinion as --

A, That's my opinion. That labyrinthine damage would do nothing to the, to the ability to have ari erection.

Q. I am speaking under normal circumstances,

when you're just not simply standing still and there is no sudden movement?

A. Right.

Q. He's testified that in the dark he can't keep his balance.

A. You are right.

Q. He's testified that: when he walks down a hall he leans or lists to the left or to the right,

A. Yes. Right.

Q. He testified that when he drives an automobile and when tic nits a bump becomes dizzy.

A. Yes.

Q. Now, is it your testimony that with these problems of balance and movement or sudden stops or any sudden physical motion or stopping of motion affecting his dizziness has no affect on his ability to get an erection?

A. Right, What I'm saying to you is that the erectile mechanism is not related in any way to the labyrinthine, in no way.

Q. You're speaking mechanically or physically?

A. Right. You're also saying, while he is driving a car he is not trying to have an erection, no.

Q. That's not what I am getting at. Seriously, when a human male in his 50s without a labyrinth wants to make love to his wife, he's just not going to stand still, there is physical contact, there is physical motion that affects his balance, his dizziness; isn't that going to interfere with nis ability to make love?

A. No. I got to tell you that the erectile mechanism can be tested and has nothing to do with any labyrinths. The erectile mechanism, the nervous conditions are tested while you're sleeping, okay, is connected to brain waives, I mean it's just a totally aifferent test, It nas nothing to do with the ears.

Q. I understand. You're talking about pure physiological tests.

MR. KWARCIAMY: You're talking about psychological affects, because ne can't maintain hi5 balance while he is making love and, therefore, he cannot get an erection?

Q. (BY MR. COTICCMIA) I don't know, When a man has his labyrinths destroyed, it physically affects his ability to maintain physical stability, isn't that correct?

A. Correct.

Q. Sudden motions, either stopping or starting cause nim to become dizzy, isn't tnat normal?

A. Wait, You mean isn't that with him?

Q. With him, that's a normal affect of loss of the labyrinths?

A. Right.

Q. Isn't that going to affect his everyday life including his ability to make love?

A. Well, again, it shouldn't, but, you know, I don't know his particular situation. There are no tests that can be done that -- there is nothing that was don& that would lead me to say that he really is organically impotent. Now, if you are talking psychological, there are tests for that,

Q. I am not talking organic or psychologic, I am saying that WE know normally what happens to a person when he loses his labyrinths, don't we?

A. Right.

Q. What happens to a person like Mr. DiMarco, he doesn't nave his labyrinths any more, aside from what caused it, what happens to a human being when he loses his labyrinths, what affect does that have on him?

A. 1 mean, he's more dizzy, just his balance

is not as good,

Q. Correct. When he walks down a hallway, do you accept his testimony that he finds himself leaning or staggering to one said or another?

A. I would have to assume it's true, yes.

Q. Now, he has no balance when it's night and the room is cark without a light on; do you accept that as true?

A. I do.

Q. Don't you think that the loss of balance is going to affect almost every aspect of his life at less when he's moving?

A. Again, if ne's lying in, if he is in bed and he's lying down, I don't know where he's trying to nave an erection, if he is lying down and he's in bed, he should be able to have an erection. And if he then goes moving around and so forth, he may get somewhat dizzy, but he should not lose that ability to maintain that erection.

Q. Don't you think it interferes with his ability to make love?

a. Again, I say it shouldn't. If he's trying to do it in a different way, I mean he is not going to dance and make love, or do something like that, but if he is in a bed, if he is in a

stable situation where he won't get dizzy, it's the dizziness that's bothering him and it's not the loss of erection,

Q. So clinically speaking -- or let's put it theoretically, if we have a model, as far as a theoretical model, if the person without labyrinths remains immobile, a male, he should be able to get an erection?

A. Assuming no other problems, right.

Q. Yes. All right. But that's not a normal way a man would make love to his wife, to remain completely immobile?

A. Again, even if he moves --

Q. Yes.

A. You can move. He'll get dizzy while he's moving, but he is not going to lose his erection,

Q. Well., he claims an inability. I don't know what, I don't know what causes it.

A. I am telling you that an arninoglycoside has nothing to do with the labyrinths. He may be impotent. There is the possibility that with a prostatectomy, they do become impotent, He may have become impotent. Again, I am not saying to you that he's not impotent, I am just saying that it's not related to this.

Q. Okay. But it certainly affects --

A. I mean, does he ever wake up in the morning with erections?

Q. 1 don't know, I haven't asked him.

A. Those are important tnings to know whether or not he really does have erectile dysfunction, and it can be, rather in a straight forward manner, tested.

Q. All right. Now, do you agree that the loss or the labyrinths affects his normal daily activities?

A. YES.

Q. That's a permanent condition, isn't it?

A. Usually.

Q. I'm talking about Mr. DiMarco.

A. That's what I mean, usually it is.

8. What evidence do you have in regard to your Letter, you mention flora following transrectal biopsy; what evidence do you have that flora was introduced?

A. I mean, as you mentioned before, we all carry bacteria. We Know we carry gram-negative bacterium within *the* homeland at all times **unless** it's specifically removed by certain preps and that type of thing. **And** you have to assume that when

you yo through the rectal mucosa, through the rectum, through a uead plane, and then into the prostate, that there is a needle tract along which the bacterium can enter and that's where you worry about it, setting up that abscess in that medial tract because there is no way for it to drain,

Q. Okay. That's a possibility. My question is, what evidence do you have that this caused the bacteria or the infection? It's just something --

A. Right. Wait. What evidence do I have that the --

Q. Of what you're talking about?

A. That the transrectal biopsy introduced the infection into the urine?

Q. Yes. Is that what you mean?

A. As I said, I mean, there's no direct evidence, you just have to -- WE just know the facts from past experience that this occurs after transrectal biopsy.

Q. It's a possibility, isn't it?

A. Right.

Q. Right. But you don't know based on a reasonable probability that this was, in fact, what happened?

a. I would say with the same probability

that the labyrinthine damage was due to the medication. I mean, you don't have a 100 percent thing there either. I think it's probable that the rectal biopsy introduced the infection. There is no other place where the infection really could have been introduced.

Q. I am quoting from the warning in the Physician's Desk Reference, 1983, under Nebcin, page 901. The risk of aminoglycoside-induced hearing loss increases with the degree of exposure to either high peak or high trough serum concentrations. Patients who develop cochlear damage may not have symptoms during therapy to warn them of eighth-nerve toxicity, and partial or total irreversible bilateral deafness may continue to develop after the drug has been discontinued.

Now, Dr. Porter, in regard to the reference to peak and trough serium concentrations, again, we don't know that in Mr. DiMarco's case, because Dr. Bernstein didn't order any?

A. Right.

MR. COTICCHIA: Okay, I don't have any more questions, Thank you for your time,

MR. KWARCIANY: For the record, the policy of our office is for the Doctor not tu

waive signature. So if you're going to have this typed up --

MA. COTICCHIA: I am,

MR. KWARCIANY: -- then please submit a transcript to the Doctor for his reading so that he can make the necessary corrections,

- - -

(Deposition concluded at 3:00 p.m.)

- - -

I have read the foregoing transcript from page 1 to page 67 and note the following corrections:

PAGE:	LINE:	CORRECTION:	REASON:

_____
ARTHUR PORTER, M.D.,

Subscribed and sworn to before me this day of , 1986.

_____
Notary Public

My **Commission Expires:**

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

I, Marguerite A. Sandly, RPR/CM and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify 'chat ARTHUR PORTER, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above set forth was reduced to writing by me by means of Stenotype and was subsequently transcribed into typewriting by means of computer-aided transcription under my direction; that said deposition was taken at the time and place aforesaid *by* agreement of counsel; ana that I am not a relative or attorney of either party or otherwise interested in the event of this action,

IN WITNESS WHEREOF, I hereunto set my hand and seal of office at Cleveland, Ohio, this 6th day of May, **1986.**

Marguerite A. Sandly, RPR/CM and Notary Public within and for the State of Ohio
540 Terminal Tower
Cleveland, Ohio 44113

My Commission Expires: October 30, 1989.