#646

THE STATE of OHIO, :
: SS:
COUNTY of LUCAS.

IN THE COURT OF COMMON PLEAS

THOMAS G. BALDWIN,
plaintiff,

vs. : Case No. 96 2365

MARK E. REARDON, M.D.,
et al.,
defendants.

Deposition of MARK E. REARDON, M.D., a defendant herein, called by the plaintiff for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Constance Campbell, a Notary Public within and for the State of Ohio, at the offices of Albrechta & Coble, 3230 Central Park West Drive, Toledo, Ohio, on WEDNESDAY, SEPTEMBER 11, 1996, commencing at 6:05 p.m. pursuant to notice,

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I N D E X

WITNESS: MARK E. REARDON, N.D.

(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

MARK E. REARDON, M.D.

of lawful age, a witness herein, called by the plaintiff for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, being first duly sworn, as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION

BY MRS. GARSON:

Q Would you state your name for the record, please.

A. Mark Edward Reardon.

Q Doctor, my name is Ann Garson, as you know we're here together to take your deposition with regard to the care and treatment rendered to Thomas Baldwin.

I'm sure your counselor already advised you we need verbal answers so the court reporter can take them down.

If I ask some questions that either don't make sense generally, or don't make medical sense, please let me know so we can come to an understanding of what I really am asking, so you can answer the question.

A. Okay

Q. Of course, if you do answer the question, I'll presume that you understood the question.

A. Okay.

Q. We've been provided with a copy of your curriculum vitae, we can mark this as Exhibit A. Would you take a look at it, please, let us know if this is current and updated.

(Plaintiff's Exhibit A marked for identification.)

MR. BODIE: We talked about recertification.

A. Yes. Actually this doesn't have where I currently am either. Do you want me to tell you that?

Q. Tell me whatever is accurate and true that is not included on there.

A. Right, because this says Westec Urgent Care '92 to present. As of 1995, January of 1995, I've been at Toledo Hospital, Occupational Medicine Clinic. That is where I currently am.

Q. Are there any other Board certifications that you have that are not listed on your CV?

A. I just recently recertified in family practice, just this Summer.

Q. There is none in addition to that?
A. No, just recertification.
Q. Is there anything else that is not on this CV that is more current?
A. Germane, no.
MR. BODIE: By way of like associations, publications, things like that?
MRS. GARSON: Yes.
MR. BODIE: Thank you.
A. No.
MR. BODIE: Hospital privileges, et cetera, that is all the same? I don't know if that was included.
MRS. GARSON: I don't think it was. We will get there.
Q. So you're currently at Toledo Hospital?
A. Yes.
Q. What is your employment relationship with Toledo Hospital?
MR. BODIE: Objection, irrelevant. Go ahead, Doctor.
A. I am employed as associate director of their occupational medicine clinic.
Q. What does that involve?
A. It involves they contract with companies to

provide medical care for their employees when they are injured on the job, provide annual physicals, pre-employment physicals, that sort of thing.

Q. Is your office actually in the hospital?

A. No, the offices are peripheral offices adjacent to Toledo Hospital,

Q. What is the office address?

A. 2150 West Central Avenue, Toledo.

Q. Do you have any other private practice in addition to that employment relationship?

A. No.

Q. I'm sorry, I have to ask this question: Has your medical license ever been suspended or revoked for any reason?

A. No.

Q. Have you ever been named as a defendant in a medical negligence case before?

A. Yes.

MR. BODIE: Objection, continuing.

MRS. GARSON: Okay.

MR. BODIE: Thank you.

Q. What was the county in which that case was filed?

A. Lucas.

Q. When was that?
A. When was it filed?
Q. Urn-hum.
A. I don't recall.
Q. Approximately the year?
A. 1993, 1994.
Q. Is that case still pending?
A. No.
Q. It's been resolved?
A. Yes.
Q. Are there any other cases that have been filed against you?
A. I had one other case that was filed, that one has been dismissed.
Q. What county and year was that?
A. It was filed also in Lucas County, it was dismissed as of last year, so it was filed the year before that I believe.
Q. Do you have active hospital privileges at this time?
A. Yes, Toledo Hospital.
Q. At Toledo, any other hospital?
A. Currently, no.
Q. Have you ever had hospital privileges suspended or revoked?

A. No.
Q. In 1990, at any time from 1990 through the present, have you had privileges at any other hospitals?
A. Yes, I have.
Q. Where were those?
A. Several. In 1990 I was in private practice, I had privileges at Toledo Hospital, Flower Hospital, and Mercy Hospital.
Q. What were the nature of those privileges?
A. Family practice privileges for admissions, care of patients, ER care privileges, et cetera.
Q. The reason you no longer have those privileges is because now you are strictly working as the occupational director at the Toledo Hospital?
A. Exactly.
Q. Did you review any records in preparation for today's deposition?
A. Yes.
Q. What did you review?
A. I reviewed my records.
Q. Pour office chart?
A. Office chart.
Q. I'm presuming your office chart included some

records from Flower Memorial Hospital as well; is that accurate?

A. Yes.

Q. Did you review medical records of Mr. Baldwin subsequent to --

MISS KOLIS: October, '91. Sorry, I can coach.

MR. BODIE: You stopped me from doing it.

Q. Subsequent to August, '91?

MR. BODIE: Doctor, that would be the last time you saw the patient.

A. No, I didn't. I reviewed nothing after I saw him the last time.

Q. My question to you is whether you reviewed them for preparation for today's deposition, your answer was no. Did you review them at all, disregarding whether it was in preparation for this deposition?

A. Are you speaking subsequent records?

Q. Yes.

A. No.

Q. Can you tell us, Doctor, what are the clinical symptoms for appendicitis?

MR. BODIE: Objection,

vague. Go ahead, Doctor, if you can.

A. In general the clinical symptoms are fever, abdominal pain, anorexia, nausea, vomiting.

When you are asking clinical symptoms, you are talking about symptoms that the patient presents with I assume?

Q. Right.

A. You are not asking me findings?

Q. Right. Is that it?

A. Yeah, pretty much.

Q. When you say abdominal pain, is there a more specific symptom or presenting complaint with regard to abdominal pain?

A. Sometimes.

Q. What is that?

A. Often it can be localized to the right lower quadrant.

Q. Would you consider localized right lower quadrant pain one of the hallmarks, if you will, of an appendicitis?

MR. BODIE: Objection. Go ahead.

A. I'm not exactly sure what you mean hallmarks. If you could explain what you mean by hallmark.

Q. Let me ask you how significant is it to you when a patient presents with a complaint of right lower quadrant pain, in addition to the fever, the nausea and vomiting?

A. It's not anymore significant necessarily than if there is pain anywhere else in the abdomen.

Q. So I'm clear, your testimony today is that right lower quadrant pain is not anymore indicative or significant to you of an appendicitis than anything else, any other symptoms that the patient might present with?

MR. BODIE: Objection, that is not what he said.

A. That isn't what I said. I said right lower quadrant pain is not more significant. You asked the question is it more significant. It isn't more significant by itself.

Q. Okay.

A. It may be more indicative of an appendicitis than say pain would be elsewhere in the abdomen.

Q. Is constipation one of the signs and symptoms that can be attendant with an appendicitis?

A. Possibly. I believe constipation could be present. That isn't often one of the things you see. Constipation isn't one of the things that

make you think Dingo, appendicitis

Q Are the signs and symptoms for a retrocecal appendicitis any different than those you've just enumerated?

A. Well, when you ask me about right lower quadrant pain, it often will -- appendicitis you often do have right lower quadrant pain. With retrocecal appendicitis the pain can be different

Q In what way?

A The pain may not be in the right lower quadrant, may be elsewhere because the retrocecal location can kind of mask the area of the pain. You might detect pain at a more distinct location from the right lower quadrant

Q. You say the pain might De felt elsewhere, where else?

A. Can be anywhere You'll have pain in any quadrant of the abdomen from appendicitis, doesn't have to De right lower quadrant

Q What are some of the findings that are typically found with appendicitis?

A You usually would see fever, elevated white count, you may see in addition to pain in the right lower quadrant often it may be at McBurney's point, you could see some rebound tenderness, loss of

bowel sounds, generally what you see is pain that doesn't relent, you don't see pain that comes and goes.

Q. Would a normal white blood count rule out appendicitis necessarily?

A. It wouldn't rule it out, no.

Q. Would the presence or absence of rebound tenderness rule out appendicitis?

MR. BODIE: Could you say that again.

Q. Would the absence of rebound necessarily rule out appendicitis?

MR. BODIE: In and of itself?

A. In other words, do you need the rebound tenderness to diagnose appendicitis?

Q. Right.

A. No.

Q. Same thing, same question as to the McBurney's point tenderness?

A. Is that specific for appendicitis?

Q. Do you necessarily have to have McBurney's point tenderness for there to be appendicitis?

A. No.

Q. You mentioned that generally an appendicitis

the pain is ongoing, doesn't come and go, is that what you said? I don't want to misquote you.

A. Yes, I said it doesn't relent.

Q. In general, are their situations where it would ebb and flow?

A. In my experience, no. I've heard that there can be cases where it could, I haven't seen it.

Q. Is one of the cases where it could be in the situation where there is an abscess that is formed?

A. You know I really don't have expertise to answer that.

Q. Do you know if there would be differing symptoms on presentation or different clinical findings where there is an abscess, as opposed to a pure and complete rupture of the appendix?

A. In my experience, my understanding, an abscess would form because of a rupture.

Q. What would be the picture of a clinical course when an abscess such as that is formed?

A. Well, in order to develop an abscess you would have to have a rupture. So there is a clinical picture to a ruptured viscus.

Q. What is the clinical picture to the rupture?'

MR. BODIE: Objection, vague. Go ahead, if you can.

A. Well, again, as with appendicitis, there is no one clinical picture; however, a ruptured viscus is generally a catastrophic event, *so* you see someone become much more ill, usually quite quickly. Increasing fever, white count, loss of bowel sounds, often then becoming -- the patient becomes septic with all the attendant symptoms associated with that, shock.

Q. I understand.

A. Downward spiral.

Q. That is a good description of the course of an acute appendicitis with a complete rupture and catastrophic event.

You were mentioning there are cases where an abscess is formed subsequent to a rupture, that this may not be the general case. You said there would be a clinical picture with that, I'm asking you what would be that clinical picture?

A. Well, if the person did not follow that clinical picture of a ruptured viscus, if an abscess forms, generally you would see again findings of infection, fever, elevated white count, pain.

Q. Right lower quadrant pain?

A. You would expect to find pain where the

abscess was, a mass. A mass in the abdomen.
Q. Nausea?
A. Nausea, anorexia.
Q. What is a psoas sign?
A. Psoas sign is there is peritoneal irritation in the abdomen, it's a maneuver whereby you can elicit increased pain. It's a way to determine if there is inflammation of the peritoneum, which generally you see because of a ruptured viscus or some infectious process in the abdomen.
Q. Is a psoas sign a significant indicator of the diagnosis of appendicitis?
MR. BODIE: Objection, form.
THE WITNESS: I'm sorry?
MR. BODIE: Objection, form of the question and I guess use of the term significant is somewhat vague.
A. Again, psoas sign, there is no one pathonomic sign for appendicitis, but psoas sign is something that you may see in appendicitis, not always.
Q. It can be helpful in making the diagnosis if it's present, correct?
A. Yes, it can be.
Q. Does the same hold true for the obturator

sign?
A. Yes, again it's another sign, another maneuver to try to determine if there is a peritoneal irritation.
Q. If I understand that correct, if what I'm saying is correct, the diagnosis of appendicitis has a laundry list or constellation of symptoms, some of which may be there, some of which may not, a patient doesn't have to have all of them to have appendicitis; is that basically accurate?
A. Yes.
Q. Let's go to when you first saw Mr. Baldwin. When was that?
A. You want the date?
Q. Yes. I think it was August 27th, does that comport with your records?
MR. BODIE: That would be the hospitalization.
A. Yes, that is true.
Q. What were the circumstances under which you came to see him on August 27th of 1990?
A. Well, he was admitted to Flower Hospital on the evening of August 26th, I had never seen him as a patient, his mother was my patient. When he was admitted he did not have a personal physician, I

don't remember exactly if it was his mother who suggested that they call me for admission, or if it was the patient himself. In any case, they called me, asked if I would accept him as a patient, and I did so.

Q. At that time, what was his chief complaint?

MR. BODIE: The time he first examined him?

MRS. GARSON: Yes.

MR. BODIE: Thank you.

A. At the time I first examined him?

Q. Um-hum.

A. Abdominal pain.

Q. Were you aware at the time you saw him August 27th that two days earlier on August 25th he had been to the Westec Urgent Care Center?

A. Let me refer to my notes. Yes, I was aware of that. After I took his history, yes.

Q. Were you aware as part of that -- let me ask you, were you aware of what his complaints were when he went to that urgent care center on August 25th?

A. Yes.

Q. What were they or what were you aware of at that time?

A. Again, referring to my notes, he had been treated for cold symptoms since two days prior to presenting to Flower Hospital, was treated for the cold symptoms.

Q. I didn't see in your office chart copies of the Westec Urgent Care records, did you ever request them or I guess my question is am I missing something, are those part of your chart?

A. If I requested them, they would be part of my chart. They aren't, I'm assuming I never did request them.

Q. Were you aware of whether Mr. Baldwin had been prescribed any medication on August 25th?

A. Again, according to my notes he was given an antibiotic and a cold preparation.

Q. Then because those records are not a part of your chart, you've just told us what you were aware of regarding that visit, were you unaware that at that August 25th visit he had complaints of diffuse abdominal tenderness?

A. No, I was not aware of that.

Q. Were you aware that he had been to the Westec Urgent Care Center on this August 27th prior to coming to Flower Memorial Hospital?

MR. BODIE: You mean 26th?

MRS. GARSON: 27th.

A. He was admitted on the 26th, I didn't see him until the 27th.

Q. Show me where you are showing he was admitted on the 26th.

A. He was admitted on the 27th, I saw him on the 28th. I saw him the next morning, he was admitted in the evening, I saw him in the morning.

Q. You saw him on the 28th. When you saw him on the 28th were you aware he had been at the Westec Urgent Care on the 27th?

A. No, I was not. It's not in my notes.

Q. Since those Westec records are not a part of your chart itself, is it fair to say you were unaware of what his presenting complaints were to the Westec Urgent Care on the 27th?

A. That is true, I'm not aware of that or I wasn't aware of that.

Q. When you saw him on the 27th, did you at any time later come to know that he had been at the urgent care on the 27th?

A. I think the first time -- the first time I saw anything to that effect was after all this began. I wasn't aware of it at any time when I was -- he was in my care.

MR. BODIE: Other than what you have dictated?

A. Exactly. I don't mention it in my dictation. If I don't mention it, either I wasn't aware of it, or -- if I would have been aware of it, I think I would have put it in my dictation.

Q. Then it's safe to say then you were unaware then that the Westec Urgent Care Center on August 27th found right lower quadrant pain, McBurney point tenderness, rebound, a positive obturator sign and positive psoas sign; that's fair to say?

A. That's true, I was not aware of that.

Q. Would anything that you did or didn't do on August 28th when you saw Mr. Baldwin have changed if you had been aware of that information?

A. No.

Q. Why is that?

A. Because a doctor is in the habit of obtaining his own information, making his own opinions based on that.

Q. Is right lower quadrant pain, low grade temperature, McBurney point tenderness, guarding, rebound, obturator positive, and psoas positive, psoas sign, are those symptoms consistent with an

appendicitis attack?
A. They could be consistent with appendicitis as well as other things.
Q. What other things?
A. They could be consistent with a number of things. Diverticulitis, they could be consistent with colitis. They could be consistent with adenitis. It could be consistent with Crohn's or ulcerative colitis, some other things that are even less prevalent.
Q. When you did your physical exam of Mr. Baldwin, some of your findings were right lower quadrant tenderness at McBurney's point and mild rebound; is that accurate?
A. Can you repeat that?
Q. When you did your physical exam of Mr. Baldwin the 28th I guess it was.
A. Yes.
Q. Some of your physical findings were right lower quadrant tenderness at McBurney's point and mild rebound; is that accurate?
A. Yes.
Q. What were your initial impressions based upon these findings?
A. Based upon those findings and everything

taken in whole, it wasn't just based on those things.

Q. Okay.

A. My impression was right lower quadrant and abdominal pain, possible appendicitis -- I'll read it -- rule out gastroenteritis versus appendicitis, possibly masked by antibiotics versus adenitis with question of prostatitis.

Q. Appendicitis was second on your differential list; is that accurate?

A. Yes.

Q. Let's start with adenitis, is it accurate to say that was mesenteric adenitis, is that what you meant?

A. Yes.

Q. What is a mesenteric adenitis?

A. Mesenteric adenitis is inflammation of the lymph nodes in the mesentery, in the abdomen.

Q. What is the clinical picture for mesentery adenitis?

A. Well, very much similar to what he had. You can have fever, abdominal pain, it can be localized or generalized, you can have all the other findings too, rebound tenderness, guarding, psoas sign.

Q. Let me ask you how do you distinguish between

mesentery adenitis and appendicitis when ruling out your differentials?

A. There is no -- again, no one way to distinguish between it.

Q. I'm asking you how you do it.

MR. BODIE: He just said there is no one way.

A. It's a clinical impression. You reach it through assessing all the information, reaching a decision -- not a decision necessarily, you can reach it at any point in time, it's a continuum.

Q. What factors would *go* into your distinguishing whether a patient had appendicitis for which he might need prompt treatment or whether he has mesenteric adenitis?

A. The most important thing I think would be the clinical course.

Q. What do you mean by that?

A. Meaning at X point in time when you have a conglomeration of symptoms and findings, you can't be sure if it's one thing as opposed to a number of others, you have to kind of watch the patient, see how he does, he or she does, That's probably the most important thing I think in deciding finally whether it's adenitis versus say appendicitis,

Q. What are you watching for?
A. Watching to see how the patient does, does he progress, does he get worse, does he get better, that is primarily what you are watching. You're assessing a number of things.

Primarily you are watching the patient, that is always the number one thing in medicine is to watch to see how the patient does. You can also assess other things along with it. White counts, fever, in addition to how the patient himself is feeling, looking at what you find on your physical exam.

Q. Was there any determination in Mr. Baldwin's case on the August 27th admission whether he had any inflammation of the lymph nodes?

MR. BODIE: At what point in time?

Q. On the August 27th admission?

MR. BODIE: Throughout the whole admission?

Q. Yes.
A. You mean between the time he was admitted and discharged? Yes.
Q. Yes what?
A. Yes, there was a determination that it was

adenitis, as opposed to --

Q. I understand that. You explained the definition of adenitis was an inflammation of the lymph nodes in the abdomen.

Was there a determination that there was an inflammation of the lymph nodes in the abdomen.

MR. BODIE: Objection, asked and answered.

Q. Show me in the record not where it says diagnosis mesenteric adenitis, where it's documented there was inflammation of lymph nodes in the abdomen.

A. Meaning is there some test or some --

Q. You didn't note it anywhere in your notes, I frankly didn't see it in anyone else's. I'm asking you to tell me whether you see it documented in these records whether there was inflammation of the abdomen?

MR. BODIE: Other than the notation adenitis, mesentery adenitis?

Q. Yes.

A. I made the diagnosis based on the whole clinical picture. It's not a diagnosis you can get confirmation. Do you mean by saying that do I have

lymph node in hand that I can say ah-hah that is inflamed, therefore I've got my diagnosis beyond a doubt? No, I didn't have that.

Q. How do you know whether or not there is an inflammation of a lymph node in order to make the diagnosis of mesenteric adenitis?

A. Well --

MR. BODIE: Objection, form.

A. It's a clinical impression mostly.

Q. How do you form that clinical impression, what factors?

A. Well, you draw up a series of differential diagnoses, you go about a process of elimination.

Q. What was that process of elimination? I want to understand the process you went through to come to the diagnosis of mesenteric adenitis.

A. Well --

Q. Is there some test that you can do that you can palpate lymph nodes in the abdomen?

A. You may be able to palpate lymph nodes, not always physically in the abdomen.

Q. Did you attempt to palpate lymph nodes in the abdomen?

A. I did palpate his abdomen, I don't recall

again looking at my notes, I don't make any notation that I palpated specific lymph nodes, no.

Q. So there is no finding in the record, I'm not missing anything, there isn't a finding noted in the records that you palpated a lymph node that you felt was inflamed?

A. No, but very often you wouldn't.

Q. Well then, once again, let me follow-up then, since you didn't note that there was inflamed lymph nodes, very often you might not, how did you come to the diagnosis of mesenteric adenitis?

MR. BODIE: Objection, asked and answered. Go ahead, Doctor.

A. Process of elimination.

Q. What was that process?

A. I considered the other possibilities, namely appendicitis, appendicitis being number one, or as I mentioned the other possibilities which I didn't necessarily list by name here, the other possibilities which would cause an acute abdomen.

It became quite apparent that this was not an acute abdomen. The course of his illness steadily and rapidly improved., which essentially ruled out appendicitis, and the other things that I might be considering that might

possibly be surgical in nature, leaving me with the symptom or the group of symptoms that he had presented with and the way that they were resolving most closely fit the clinical picture of mesenteric adenitis, that is how I reached the diagnosis.

Q. Let's go at it a different way. How did you rule out appendicitis?

A. Again, it wasn't any one thing, it was looking at the way that this illness evolved.

Q. Did you order any diagnostic tests in order to rule out any of your differential diagnoses?

A. Yes, I did.

Q. What did you order?

A. Initially --

MR. BODIE: What do you need to see, Doctor?

A. I don't remember everything right off the top of my head I ordered.

MR. BODIE: Here is the order sheet, you can go through this.

A. A CBC, chemistry profile, urinalysis, culture and sensitivity, then a liver profile, amylase, chest x-ray, another CBC later on. I believe he had had abdominal x-rays that were done in the emergency room so that was --

Q. Does the CBC, do the results of the CBC assist you in ruling out appendicitis in this case?
A. Yes.
Q. In what way?
A. Well, almost always in appendicitis you have an elevated CBC. When you don't see an elevated CBC that tends to make you much less suspicious of appendicitis.
Q. Even though you already testified here today that not having an elevated CBC doesn't necessarily rule out appendicitis, correct?
A. I would never say that a normal CBC would rule out appendicitis.
Q. Did the liver enzymes testing help you or assist you in ruling out appendicitis?
A. They assisted me in the scope that they were negative. If they were positive -- that is something that you would look at if it was positive certainly.
Q. The normal liver enzyme testing you did does not rule out an appendicitis, correct?
A. No.
Q. The chest x-ray, that doesn't help you rule out appendicitis, does it?
A. Everything helps you a little bit in ruling

it out or a lot. Everything adds in. If you are saying does any one thing or any -- again, just as there are a group of symptoms, even if you have all those classic symptoms doesn't tell you you have a appendicitis, there is only one way to know for sure if you have appendicitis.

Q. What is that?

A. Surgically.

Q. What are the indications for surgically determining whether someone has appendicitis?

MR. BODIE: Let me object. I think that is better addressed to a general surgeon.

A. That was going to be my answer.

Q. I thought you might want to answer since you were the one that said the only way to know for sure is to go in and look.

A. That is the only way you can know 100 percent, yes.

Q. What about the abdominal x-rays, do you know what the results of those were?

A. Yes, I do. They are right in front of me, normal.

Q. Is it unusual for someone with an appendicitis to have a normal abdominal x-ray?

A No. It's not unusual

Q It's probably more common for someone with a retrocecal appendicitis to have a normal abdominal film?

A. Are you telling me?

Q I'm asking

A Sounded like you were telling me

No one absolutely honest. I don't know that that is true Appendicitis can present with a normal abdominal x-ray. So I would assume that a retrocecal appendicitis could also present with a normal abdominal x-ray

Q Are there any diagnostic tests that would be helpful in ruling out an appendicitis or abscess?

A Which one?

Q I'm sorry. Are there any diagnostic tests that would assist in ruling out an appendicitis?

A. There are other diagnostic tests that could assist.

Q. What are those?

A Other than what I mentioned?

Q. Um-hum.

A. A CT scan could assist in ruling it out.

Q Did you consider ordering a CT scan for Mr. Baldwin on August 27th of 1990?

A. I didn't see --
Q. August 28th or during his hospital stay?
A. Yes, I considered it.
Q. You decided not to order it?
A. Yes.
Q. Why was that?
A. Primarily because of his clinical picture.
Q. Tell me what you mean by that.
A. Meaning that he improved, he improved rapidly, it was very quickly becoming apparent that this was not an appendicitis.
Q. At what point did you consider and decide against the abdominal CT?
A. Well, I don't remember the exact point in time.
Q. Was it when you were thinking --
A. I never considered it strongly because when I saw him the first time he was not -- surgery was not an eminent thing. I generally would not order a CT scan unless I thought there was a strong indication for it, I didn't feel there was a strong indication for it at any point.
Q. What is the indication for doing a CT scan to rule out appendicitis?
A. To be frank, again, number one, I'm not a

surgeon.

ahead

A

where -- I wouldn't order a CT scan unless it was to the point where I felt this man was likely to need surgery. Frankly, if he was likely to need surgery I would have a surgeon involved, then the surgeon would then decide whether he needed a CT scan or not. Do you follow my --

Q. You did call in a surgeon on this case, didn't you?

A. Yes.

Q. What was your thinking in why you called in a surgeon, you must have thought surgery was a

possibility here; is that true?
A. When I ordered the consult for a surgeon, surgery was a possibility.
Q. What led you to believe that surgery was a possibility?
A. Well, when you are thinking that when appendicitis -- when acute appendicitis is in your differential diagnosis, you have to think of the possibility of surgery, that goes hand and hand with it.
Q. If you were thinking the possibility of surgery you said that was a situation where you would order a CAT scan, right?
A. I said if I thought surgery was imminent.
Q. Not the possibility but imminent?
A. Yes, if surgery was likely. Frankly, as I said, I don't order CT scans for the abdomen, that is generally the surgeon's --
Q. What about ultrasounds, are those diagnostic or helpful in diagnosing or ruling out appendicitis?
A. Again, this is really out of my area of expertise. In my experience, this may have changed since then, at that point in time, ultrasounds I don't believe were being used a lot to diagnose

acute appendicitis, I still don't think they are.
Q. What is done to diagnose acute appendicitis?
A. Generally it's a clinical impression.
Q. What about barium enemas, are those diagnostic in ruling out appendicitis?
A. No.
Q. Why not?
A. As I said before, there is nothing that is diagnostic in ruling out appendicitis.
Q. Not a barium x-ray?
A. It's not diagnostic, no. You can have a normal barium x-ray with appendicitis too.
Q. Let's talk about the surgical consultation. If I understood you or heard you correctly, you were thinking, you were considering appendicitis as a possible diagnosis, correct?
A. Yes, it was in my differential.
Q. Because you were considering or because appendicitis was within your differential, surgery was a possibility?
A. Yes.
Q. Because surgery was a possibility you called in for a surgical consult; is that accurate?
A. Yes.
Q. Did you actually speak -- who did you call

in?

Dr. Sogocio.

Q. Did you actually speak with Dr. Sogocio?

A. At what point are you referring to?

Q. At the point when you called him in to assist you in the care of Mr. Baldwin?

A. I doubt that I spoke to him initially personally. I may have.

Q. Do you recall any conversations with Dr. Sogocio regarding Mr. Baldwin in late August, 1990?

A. At any point during the course?

Q. Yes.

A. Sure.

Q. Tell me what you remember.

A. Again, I have to refer to my notes. I don't believe I have those notes.

MR. BODIE: What are you looking for, Doctor, progress notes?

THE WITNESS: Progress notes. I don't have the progress notes in my chart.

A. On the evening of August 28th, at or just prior to 5:55 p.m. --

Q. Let me interrupt so I can get my page. What

page are you looking at?

MR. BODIE: 8-28 progress note.

MRS. GARSON: Maybe you're not the only one that doesn't have it in your chart.

MR. BODIE: Can I take a break?

(Recess had.)

BY MRS. GARSON:

Q. So we are at the point where you're considering --

MR. BODIE: He brought in a surgical consult.

A. Correct.

Q. You were going to tell me about the conversations that you remember with Dr. Sogocio.

A. As the record states, I saw the patient with Dr. Sogocio, after I finished my office hours for the day I went back to see the patient. At some point during the day I believe that it was agreed upon with Dr. Sogocio that I would meet him there. Something to that effect. We would examine him

together, see how he was doing, as opposed to how I had seen him earlier that morning.

Q. You examined him together?

A. Yes.

Q. At what time was that?

A. Again it was right around six o'clock, a little bit before.

Q. Do you recall any conversations that you had at that time?

A. With Dr. Sogocio?

Q. Yes.

A. I don't remember all the specifics because I didn't put all the specifics in here. The basic gist of it was boy this sure isn't looking like appendicitis now.

Q. Were those your words or his words?

A. I said that was the general gist, not the exact words.

Q. Not the exact words, who was speaking that?

A. It was an agreement, We totally agreed.

Q. It was an agreement between both of you?

A. Yes.

Q. Was it at that time on the 28th that a decision was made to not conduct a surgery?

A. Yes.

Q. Whose decision was that?
A. It's the surgeon's decision whether to conduct surgery or not.
Q. Did you agree with that decision?
A. Yes.
Q. You stated that you saw him on the 28th, at that time the gist of it was it sure doesn't look like appendicitis now, right?
A. Yes.
Q. What was the basis for that conclusion?
A. As I said before, the way the patient looked, the way his symptoms, the way he felt, clinical findings, just the overall picture.
Q. When was he discharged?
A. August 30th.
Q. Then you saw Mr. Baldwin, approximately from August of 1990 through September of 1991?
A. I believe that is correct.
MR. BODIE: August 26th.
A. August 26 of '91, that's the exact date.
Q. Over that period of time when he came to see you, what were his presenting -- his general presenting complaints? Let's Look at the July 23, 1991 office visit.
A. July 23, 1991.

Q. I'm sorry, back up, you saw him on September 7th of 1990?
A. 1990, yes, I did.
Q. Let's look at the office visit. When he came to your office, what was the purpose of the visit?
A. It was a follow-up visit.
Q. Did he have any presenting symptoms at that time?
A. No, he didn't.
Q. Did you conduct a physical exam?
A. Yes, I did.
Q. What were your findings?
A. He appeared healthy, his abdomen was benign, meaning there were no findings, no lymphadenopathy.
Q. What is the significance of lymphadenopathy?
A. That means enlarged lymph glands.
Q. In any particular place?
A. Meaning primarily abdominal since that is where his symptoms were.
Q. That was basically the follow-up with the primary diagnosis that had been made in the hospital of mesenteric adenitis?
A. Yes.
Q. What was your assessment at that time?
A. That this was a resolved mesenteric adenitis.

Q. Is that unusual for mesenteric adenitis to simply resolve on its own?
A. No, that is the clinical picture of mesenteric adenitis.
Q. Did you do any blood work as follow-up for the hospitalization?
A. Not as a follow-up for the hospitalization.
Q. Is there any reason why?
A. No, that's why I didn't, there wasn't a reason why, he was better. Frankly, his blood work in the hospital was normal. Since he was completely resolved there was no reason at all to obtain any other blood work.
Q. You saw him again July 23, 1991?
A. Correct.
Q. What were his presenting complaints at that visit?
A. He had been having stomach pain for the last two days, which he described as epigastric in location. No nausea, vomiting, no diarrhea. He had been seen again in the ER, they had discharged him. Either they suggested that he see me again, or he decided on his own, I don't recall exactly.
Q. What was your assessment as of that visit?
A. My assessment was he was suffering from

gastritis and possibly an ulcer at that point.

Q. What was the basis for that assessment?

A. Number one, he had epigastric pain, which generally means, generally indicates stomach and the clinical picture of gastritis or ulcer, early ulcer would be consistent with that.

Also the fact that he admitted to some episodes of binge drinking, which is very commonly seen with episodes of gastritis or very commonly associated with gastritis. Those were the primary reasons that I considered those two diagnoses.

Q.

aware that the day before he had been seen in the emergency room at Flower Memorial Hospital?

A. Yes, I was -- it's in my note.

Q. I think the hospital record, some of the hospital records are also in your chart. Were you aware at the time of your visit that when he went to the emergency department the day before, that he had had a point tenderness in the right lower quadrant?

A. Are you asking me was I aware of it at the time of his visit?

Q. Right.

A. No.
Q. Do you know when you became aware of it?
A. I can't say for sure. I wasn't aware of it until right now.
Q. The record itself is a part of your chart, I believe, let me make sure I'm not misstating.
A. You may be.
Q It's the July 22, 1991 emergency room record.
A. Okay, I see that now.
Q. As your office procedure, let me understand how you obtain the emergency room record and make them a part of your own chart at your office.
A. As patients are seen in the emergency room, the emergency room will make a copy with -- take a copy of that record, send it to the attending physician, then we put it in that appropriate chart.
Q. Is there any way from your office chart to know when you received that July 22nd record from Flower Memorial Hospital?
A. Yes, it's stamped on the front July 26th.
Q. Did you review it at that time?
A. Yes, I did.
Q. Did the fact that he had point tenderness in

the right lower quadrant change any of your assessments for Mr. Baldwin at that time?

A No

Q Is there any particular reason why?

A It wouldn't have changed. Again, a doctor is trained to make a decision based on what he sees, what he finds.

Q. Let me ask you, if you had known that he had right lower quadrant tenderness at the time you saw him on July 23rd, would your diagnosis or differential still have been gastritis, rule out peptic ulcer?

MR BODIS: Objection. He did not have point tenderness at the time he saw him

MRS GARSON: It's not in his office note, it's in his hospital record

MISS OLIS: He was asking -- the question was asked in the present tense, he wants you to reask if he had become aware that he had point tenderness on July 22nd

MR BODIS: Assumes to July 23rd. Your question assumes he did have a point tenderness on the 23rd, there is no indication he did.

Q. If you had been aware July 23rd that he had had right lower quadrant point tenderness on the 22nd, would your assessment still have been gastritis, rule out peptic ulcer?

A. Possibly not.

Q. Why not?

A. Well, you are asking me would it have been, I don't know. This is all speculation. That is not what I saw on July 23rd.

Can I make a suggestion?

MR. BODIE: No. Go ahead. It's her opportunity to ask questions, Doctor.

THE WITNESS: I'm sorry.

Q. On August I think it's the 6th, I have a hole punched through mine.

A. August 6, 1991.

Q. Was that your next visit with Mr. Baldwin?

A. Yes, it was.

Q. At that time, what was his presenting complaint?

A. Continues to have intermittent abdominal pain, seems to be more during the day, worse after eating, or sometimes even drinking.

Q. At that time you have in your notes you were aware he was seen in the emergency room yesterday,

correct?
A. Yes.
Q. What was your physical exam or objective findings?
A. My exam showed he still had tenderness in the epigastric area, also in the right mid to lower quadrants.
Q. Of what significance was it to you he had pain in the right mid to lower quadrant?
A. Well, the significance was he had pain, I don't know that I attached any special significance other than that.
Q. You didn't at that time renew your suspicion of a possible appendicitis, did you?
A. No, I didn't.
Q. Is right lower quadrant pain consistent with peptic ulcer disease?
A. It can be.
Q. At this point you ordered some additional tests; is that correct?
A. Yes.
Q. What did you order and what was the purpose?
A. I obtained an upper GI series, a gallbladder ultrasound and the purpose was to determine if he may have an ulcer, primarily to determine if he had

an ulcer or not

Q. What kind of an ulcer?

A A stomach or intestinal ulcer

Q What were the results of those tests or what did you conclude?

A I don't have tests here it is, wonder GI. I'll read the impression Mild thickening of the duodenal bulb, small patchy, intermittent barium, without discernible ulcer crater.

Q What were the results of -- you did a gallbladder ultrasound as well?

A That was normal.

Q What were your conclusions at the conclusion of those tests?

A Well, my conclusion was that it was probably a duodenal ulcer, or one in the making There was thickening of the duodenal bulb, which is the first part the duodenum. Intermittent barium, not a definite ulcer crater, it's suspicious of infection or inflammation, possible ulcer, early ulcer.

Q Is pain in the right lower quadrant of the abdomen consistent with a duodenal ulcer?

A It can be.

Q In what circumstances?

A Under any circumstances. You can have pain

anywhere in the abdomen from an ulcer. Remember he also had epigastric pain, which is more consistent with duodenal ulcer.

Q. On August 26, 1991, what was your objective exam findings at that time?

A. The objective findings?

Q. Um-hum.

A. Abdomen was soft, tender in the right upper, lower quadrant. Then I mention the results of the tests.

Q. Did you on August 26th renew any suspicion for a possible appendicitis?

A. No.

Q. I assume you've been made aware that Mr. Baldwin eventually was diagnosed with a ruptured appendix; is that true?

A. Yes.

MR. BODIE: Let me object to the form, "eventually." It presupposes that it was in existence beforehand or at any point in time Dr. Reardon was treating the patient.

A. Let me say that I'm aware that was the diagnosis at the time of surgery.

Q. That's all I meant.

A. I wouldn't make any comment further other

than I'm aware of that diagnosis, yes.

Q. Let me make sure I understand. Let me ask, do you have now or will you be offering any opinion to a reasonable degree of medical certainty at this trial or at any other time, as to when that appendix ruptured?

MR. BODIE: Let me just object. He has not looked at those records, I haven't asked him to look.

MRS. GARSON: I know.

MR. BODIE: If he does look at the record, is asked to render an opinion, I will inform you promptly, well before the time, to give you an opportunity to explore that. At this point in time he has not been asked to do that.

MISS KOLIS: So the record is clear, since I'm the lead counsel and will try the case, you are saying should he come to some opinion, you are going to advise me prior to the time of trial, we can reconvene the deposition, I can explore that with him?

MR. BODIE: Absolutely.

MISS KOLIS: Fair enough.

Q. This may be along the same line. Let me ask you to make sure we've got it out on the table.

Have you looked at the pathology report from the surgery of October, '92?

A. No.

Q. Fine.

Do you know or are you able to explain what some of the complications of a chronic abscess of the appendix might be?

A. I think you asked me about symptoms of an abscess before, I did respond.

Q. Then I'm not being clear, I meant complication from such an abscess existing for a long period of time or being chronic.

MR. BODIE: Let me just object, with respect to what you mean by "long period of time," with respect to what you mean by "chronic," with respect to what you mean by "complications." I think the use of those terms in this question are somewhat vague, there can be many different complications ranging from I just have a bad tummy to death. I think it's overly broad and vague as now posed.

A. It's too broad and vague. I don't know why you are asking me. At the time I saw him he didn't have a chronic abscess.

Q. What time frame would you say is a chronic

abscess?

MR. BODIE: Objection.

A. I'm totally unable to answer whether there is any time frame.

Q. You are unable to answer that question?

A. Yes.

Q. As to what kind of time frame is involved before an abscess can be termed chronic?

A. I think you're being somewhat redundant. Abscess itself is indicative of a chronic process.

Q. How is it that you know he did not have an abscess at the time that you saw him?

A. I saw no findings of an abscess whatsoever.

Q. What are the findings of abscess?

A. That I did mention before, a mass, number one. A precipitating event that would have led to an abscess, which I didn't see at all.

Q. You don't consider the August 27th or 28th event as being a precipitating event at all?

Q. For?

A. For abscess at all?

Q. For ruptured appendix and abscess?

A. No, I don't.

MRS. GARSON: Let me see you for a second.

(Recess had.)

BY MRS. GARSON:

Q. I know you are not a surgeon, I may already know the answer to my question, let me ask.

Are you aware of any contra-indication for laparotomies?

MR. BODIE: Objection.

A. No, I can't answer that.

MR. BODIE: Objection.

Q. I understand. Will you be offering any opinions about rates of negative exploration regarding appendicitis?

MR. BODIE: Objection.

A. No, I don't plan to offer that opinion.

Q. As of your last visit with Mr. Baldwin, I think you had a note that referred him to Dr. Behrle?

A. Behrle.

MR. BODIE: B-e-h-r-1-e.

Q. What is Dr. Behrle?

A. A gastroenterologist.

Q. Are you aware if Mr. Baldwin ever actually saw him?

A. He saw his partner, Dr. Padda.
Q. Are you aware of what the results of that consultation was?
A. Yes.
Q. What was it?
A. You want just the results, is that what you are asking me?
Q. Sure.
A. Assessment, symptoms consistent with duodenitis, gastritis.
Q. Let me ask you, Doctor, does that assessment give you an adequate explanation for this gentleman's right lower quadrant pain he had since the first admission to Flowers in August of '90?
MR. BODIE: Objection. There is no indication that he had this ongoing problem.
Q. I'm not going to say he had it every day. On repeated occasions it is documented Mr. Baldwin had a right lower quadrant tenderness, in August of 1990 through September of 1991.
My question to you is: Did this diagnosis of duodenitis and gastritis, was that a satisfactory explanation for you?
A. It was a satisfactory explanation for me as

to what problems he was having at that time, 1991.

Q. Has there ever been an explanation or cause that you believe for Mr. Baldwin's right lower quadrant tenderness?

A. At what point?

Q. Again, I'm referring to the repeated documentation of right lower quadrant tenderness he experienced August of '90 through September of '91 while you were treating him?

A. Let me try to clarify how I saw his problems.

Q. Please do.

A. I saw him in August of 1990, at that point he was having right lower quadrant abdominal pain. At that point I feel very, very positive he did not have acute appendicitis, that he had mesenteric adenitis or a benign cause for abdominal pain which resolved completely.

I saw him again one year later, at that point he had some right lower quadrant abdominal pain, more so epigastric pain, much more so, The epigastric pain was more apparent. Most times, very many times when you have abdominal pain you can have abdominal pain elsewhere to the primary site of the epigastric pain.

At that point I zeroed in on that,

found an adequate diagnosis which was agreed upon completely by the gastroenterologist, a specialist in this field of discipline who I had chosen to send him to, who I did not by the way correspond with in between. We reached these diagnoses independently.

If you are asking me am I satisfied with this diagnosis. Yes, I am, for what was going on in 1991, which I don't believe was the same thing that was going on in 1990.

I believe the diagnosis that I reached in 1990, again along with the aid of a separate specialist, was the the problem that he had then. People have abdominal pain more than once in their life. It does happen. That is what happened in his case.

Q. When someone has epigastric pain that then becomes generalized, does that lead to an indication or suspicion of something other than gastritis?

MR. BODIE: Objection.

A. Are you asking me about this patient or asking me in general?

Q. I'll ask you in this patient on August 3rd of '91 when he was seen in Flower Memorial

Hospital, he had epigastric pain which then became generalized. I'm looking at it, I'm sure it's in your record.

A. When was this one again?

Q. This is in August of '91.

Let me ask you in general if someone has epigastric pain, it then becomes generalized, is this an indication that the diagnosis is more than just gastritis?

A. Not necessarily, no.

MRS. GARSON: I don't think I have anything further for you.

MR. BODIE: We will reserve.

MISS KOLIS: You'll be reading. We will have it transcribed, I have all my depositions transcribed. For the record, we of course will be willing to waive the seven day requirement.

MR. BODIE: Great.

(Deposition concluded; signature not waived.)

ERRATA SHEET

NOTATION PAGE/LINE

I have read the foregoing transcript and the same is true and accurate.

MARK E. REARDON, M.D.

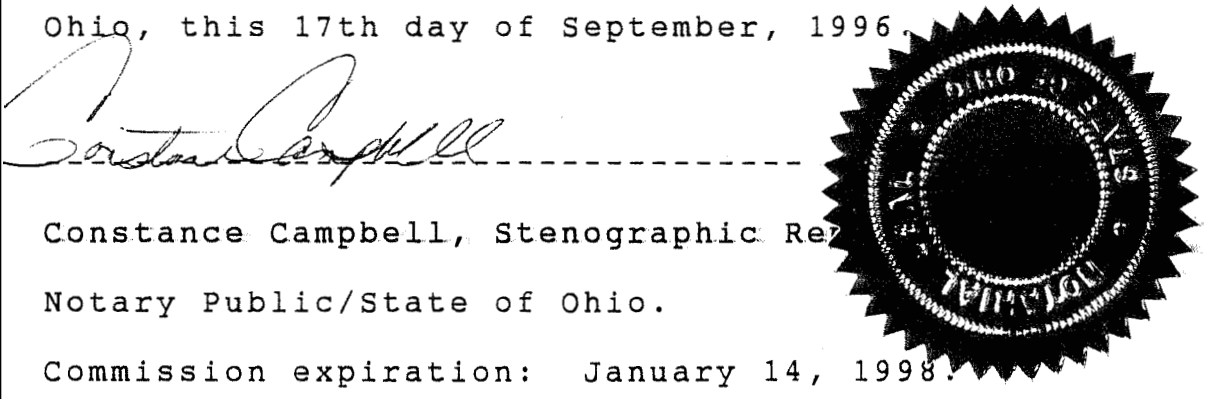
The State of Ohio,

County of Cuyahoga. CERTIFICATE:

I, Constance Campbell, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, MARK E. REARDON, M.D. was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 17th day of September, 1996.



Constance Campbell, Stenographic Re

Notary Public/State of Ohio.

Commission expiration: January 14, 1998.

Look-See Concordance Report

UNIQUE WORDS: **842**
TOTAL OCCURRENCES: **2,872**
NOISE WORDS: **385**
TOTAL WORDS IN FILE: **9,344**

SINGLE FILE CONCORDANCE

CASE SENSITIVE

PHRASE WORD LIST(S):

NOISE WORD LIST(S): **NOISE.NOI**

COVER PAGES = **4**

INCLUDES ONLY TEXT **OF:**
QUESTIONS
ANSWERS
COLLOQUY
PARENTHETICALS
EXHIBITS

DATES ON

INCLUDES PURE NUMBERS

POSSESSIVE FORMS **ON**

MAXIMUM TRACKED OCCURRENCE THRESHOLD: 50

NUMBER OF **WORDS** SURPASSING OCCURRENCE THRESHOLD: **3**

LIST **OF** THRESHOLD WORDS:

appendicitis [71]
BODIE [55]
pain [52]

* *DATES* *

August [5]
10:10; 47:14; 55:14; 56:8; 58:5
August, 1990 [1]
38:11
August 3rd [1]
57:24
August 6, 1991 [1]
47:16
August 25th [4]
19:15, 22; 20:13, 19
August 26 [1]
41:20
August 26, 1991 [1]
50:4
August 26th [3]
18:23; 41:19; 50:11
August 27th [9]
18:15, 21; 19:15; 20:23; 22:9; 26:14, 18; 33:25; 53:18
August 28th [3]
22:15; 34:2; 38:23
August 30th [1]
41:15
August of 1990 [3]
41:17; 55:20; 56:12
January of 1995 [1]
5:19
Juiy 22, 1991 [1]
45:8
July 22nd [2]
45:20; 46:21
July 23, 1991 [3]
41:23, 25; 43:14
July 23rd [4]
46:10, 23; 47:1, 9
July 26th [1]
45:22
October [2]
10:6; 52:2
September [1]
56:8
September 7th [1]
42:2
September of 1991 [2]
41:17; 55:21

* 1 *

100 [1]
32:19
1990 [13]
9:2, 7; 18:21; 33:25; 38:11; 41:17; 42:2, 3; 55:21; 56:12; 57:10, 12
1991 [10]
41:17, 24, 25; 43:14; 45:8; 47:16; 50:4; 55:21; 56:1; 57:9
1993 [1]
8:6
1994 [1]
8:6
1995 [2]
5:19

* 2 *

2150 [1]
7:8
22 [1]
45:8
22nd [3]
45:20; 46:21; 47:3
23 [3]
41:23, 25; 43:14
23rd [5]
46:10, 23, 24; 47:1, 9
25th [4]
19:15, 22; 20:13, 19
26 [2]
41:20; 50:4
26th [7]
18:23; 20:25; 21:2, 5; 41:19; 45:22; 50:11
27th [16]
18:15, 21; 19:15; 20:23; 21:1, 3, 6, 11, 16, 19, 21; 22:9; 26:14, 18; 33:25; 53:18
28th [10]
21:7, 9, io; 22:15; 23:17; 34:2; 38:23; 40:23; 41:6; 53:18

* * 3 * *

30th [1]
41:15
3rd [1]
57:24

* 5 *

5:55 [1]
38:24

* 6 *

6 [1]
47:16
6th [1]
47:14

* * 7 * *

7th [1]
42:2

* 8 *

8-28 [1]
39:2

* * g * *

90 [2]
55:14; 56:8
91 [6]
10:6, 10; 41:20; 56:8; 57:25; 58:5
92 [2]
5:19; 52:2

* * A * *

Abdomen [1]
50:8
abdomen [21]
12:6, 20; 13:18; 17:1, 6, 10; 24:18; 27:4, 7, 13, 19; 28:20, 22, 24, 25; 29:20, 22; 36:17; 42:13; 49:22; 50:1
Abdominal [1]
19:13
abdominal [21]
11:3, 11, 13; 20:20; 24:5, 22; 30:24; 32:20, 25; 33:3, 10, 12; 34:13; 42:18; 47:21; 56:13, 16, 20, 22, 23; 57:14
able [2]
28:21; 52:5
Abscess [1]
53:10
abscess [21]
15:9, 14, 17, 19, 20; 16:15, 21; 17:1; 33:14; 52:7, 9, 11, 24; 53:1, 8, 12, 13, 14, 17, 21, 22
absence [2]
14:7, 11
Absolutely [1]
51:22
absolutely [1]
33:8
accept [1]
19:4
according [1]
20:14
accurate [8]
5:16; 10:2; 18:10; 23:14, 21; 24:10, 12; 37:23
active [1]
8:19
acute [7]
16:12; 29:20, 22; 36:7; 37:1, 2; 56:15
addition [5]
6:1; 7:10; 12:3; 13:23; 26:10
additional [1]
48:19
address [1]
7:7

* * $ * *

* * C * *

* * E * *

* * F * *

* * M * *

* * N * *

* * O * *

* * P * *

* * Q * *

* * R * *

* * T * *

* * U * *

* * V * *

* * W * *