

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

#646

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 XWITNESS:MARK E. REARDON, N.D.PAGE

Cross-examination by Mrs. Garson

4

PLAINTIFF'S EXHIBITSMARKED

A - Dr. Reardon's curriculum vitae

5

(FOR COMPLETE INDEX, SEE APPENDIX)(IF ASCII DISK ORDERED, SEE BACK COVER)

MARK E. REARDON, M.D.

of lawful age, a defendant herein, called upon the
 plaintiff for the purposes 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
 were here today to take your deposition with
 regard to the car you treatment rendered to
 Thomas Baldwin.

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

Is I ask you 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

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

3 A. Okay.

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

8 -----

9 (Plaintiff's Exhibit A marked for identification.)

10 -----

11 MR. BODIE: We talked about
12 recertification.

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

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

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

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

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

1 Q. There is none in addition to that?

2 A. No, just recertification.

3 Q. Is there anything else that is not on this CV
4 that is more current?

5 A. Germane, no.

6 MR. BODIE: By way of like
7 associations, publications, things like that?

8 MRS. GARSON: Yes.

9 MR. BODIE: Thank you.

10 A. No.

11 MR. BODIE: Hospital
12 privileges, et cetera, that is all the same? I
13 don't know if that was included.

14 MRS. GARSON: I don't think
15 it was. we will get there.

16 Q. So you're currently at Toledo Hospital?

17 A. Yes.

18 Q. What is your employment relationship with
19 Toledo Hospital?

20 MR. BODIE: Objection,
21 irrelevant. Go ahead, Doctor.

22 A. I am employed as associate director of their
23 occupational medicine clinic.

24 Q. What does that involve?

25 A. It involves they contract with companies to

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

4 Q. Is your office actually in the hospital?

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

7 Q. What is the office address?

8 A. 2150 West Central Avenue, Toledo.

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

11 A. No.

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

15 A. No.

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

18 A. Yes.

19 MR. BODIE: Objection,
20 continuing.

21 MRS. GARSON: Okay.

22 MR. BODIE: Thank you.

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

25 A. Lucas.

1 Q. When was that?

2 A. When was it filed?

3 Q. Um-hum.

4 A. I don't recall.

5 Q. Approximately the year?

6 A. 1993, 1994.

7 Q. Is that case still pending?

8 A. No.

9 Q. It's been resolved?

10 A. Yes.

11 Q. Are there any other cases that have been
12 filed against you?

13 A. I had one other case that was filed, that one
14 has been dismissed.

15 Q. What county and year was that?

16 A. It was filed also in Lucas County, it was
17 dismissed as of last year, so it was filed the year
18 before that I believe.

19 Q. Do you have active hospital privileges at
20 this time?

21 A. Yes, Toledo Hospital.

22 Q. At Toledo, any other hospital?

23 A. Currently, no.

24 Q. Have you ever had hospital privileges
25 suspended or revoked?

1 A. No.

2 Q. In 1990, at any time from 1990 through the
3 present, have you had privileges at any other
4 hospitals?

5 A. Yes, I have.

6 Q. Where were those?

7 A. Several. In 1990 I was in private practice,
8 I had privileges at Toledo Hospital, Flower
9 Hospital, and Mercy Hospital.

10 Q. What were the nature of those privileges?

11 A. Family practice privileges for admissions,
12 care of patients, ER care privileges, et cetera.

13 Q. The reason you no longer have those
14 privileges is because now you are strictly working
15 as the occupational director at the Toledo
16 Hospital?

17 A. Exactly.

18 Q. Did you review any records in preparation for
19 today's deposition?

20 A. Yes.

21 Q. What did you review?

22 A. I reviewed my records.

23 Q. Pour office chart?

24 A. Office chart.

25 Q. I'm presuming your office chart included some

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

3 A. Yes.

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

6 MISS KOLIS: October, '91.

7 Sorry, I can coach.

8 MR. BODIE: You stopped me
9 from doing it.

10 Q. Subsequent to August, '91?

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

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

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

20 A. Are you speaking subsequent records?

21 Q. Yes.

22 A. No.

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

25 MR. BODIE: Objection,

1 vague. Go ahead, Doctor, if you can.

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

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

7 Q. Right.

8 A. You are not asking me findings?

9 Q. Right. Is that it?

10 A. Yeah, pretty much.

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

14 A. Sometimes.

15 Q. What is that?

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

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

21 MR. BODIE: Objection. Go
22 ahead.

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

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

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

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

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

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

18 Q. Okay.

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

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

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

1 maple you think Sings, appendicitis

2 Q Are the signs and symptoms for a retrocal
3 appendicitis any different than those you've just
4 enumerated?

5 A. Well, when you see me about right lower
6 quadrant pain, it often will -- appendicitis you
7 often do have right lower quadrant pain. With
8 retrocal appendicitis the pain can be different

9 Q In what way?

10 A The pain may not be in the right lower
11 quadrant. May be elsewhere because the retrocal
12 location can kind of mask the area of the pain.
13 You might detect pain at a more distinct location
14 from the right lower quadrant

15 Q. You say the pain might be felt elsewhere.
16 where else?

17 A. Can be anywhere. You can have pain in any
18 quadrant of the abdomen from appendicitis. Doesn't
19 have to be right lower quadrant

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

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

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

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

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

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

9 MR. BODIE: Could you say
10 that again.

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

13 MR. BODIE: In and of
14 itself?

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

17 Q. Right.

18 A. No.

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

21 A. Is that specific for appendicitis?

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

24 A. No.

25 Q. You mentioned that generally an appendicitis

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

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

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

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

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

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

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

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

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

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

23 Q. What is the clinical picture to the **rupture?**

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

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

9 Q. I understand.

10 A. Downward spiral.

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

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

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

24 Q. Right lower quadrant pain?

25 A. You would expect to find pain where the

1 abscess was, a mass. A mass in the abdomen.

2 Q. Nausea?

3 A. Nausea, anorexia.

4 Q. What is a psoas sign?

5 A. Psoas sign is there is peritoneal irritation
6 in the abdomen, it's a maneuver whereby you can
7 elicit increased pain. It's a way to determine if
8 there is inflammation of the peritoneum, which
9 generally you see because of a ruptured viscus or
10 some infectious process in the abdomen.

11 Q. Is a psoas sign a significant indicator of
12 the diagnosis of appendicitis?

13 MR. BODIE: Objection,

14 form.

15 THE WITNESS: I'm sorry?

16 MR. BODIE: Objection, form
17 of the question and I guess use of the term
18 significant is somewhat vague.

19 A. Again, psoas sign, there is no one pathonomic
20 sign for appendicitis, but psoas sign is something
21 that you may see in appendicitis, not always.

22 Q. It can be helpful in making the diagnosis if
23 it's present, correct?

24 A. Yes, it can be.

25 Q. Does the same hold true for the obturator

1 sign?

2 A. Yes, again it's another sign, another
3 maneuver to try to determine if there is a
4 peritoneal irritation.

5 Q. If I understand that correct, if what I'm
6 saying is correct, the diagnosis of appendicitis
7 has a laundry list or constellation of symptoms,
8 some of which may be there, some of which may not,
9 a patient doesn't have to have all of them to have
10 appendicitis; is that basically accurate?

11 A. Yes.

12 Q. Let's go to when you first saw Mr. Baldwin.
13 When was that?

14 A. You want the date?

15 Q. Yes. I think it was August 27th, does that
16 comport with your records?

17 MR. BODIE: That would be
18 the hospitalization.

19 A. Yes, that is true.

20 Q. What were the circumstances under which you
21 came to see him on August 27th of 1990?

22 A. Well, he was admitted to Flower Hospital on
23 the evening of August 26th, I had never seen him as
24 a patient, his mother was my patient. When he was
25 admitted he did not have a personal physician, I

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

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

7 MR. BODIE: The time he
8 first examined him?

9 MRS. GARSON: Yes.

10 MR. BODIE: Thank you.

11 A. At the time I first examined him?

12 Q. Um-hum.

13 A. Abdominal pain.

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

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

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

23 A.. Yes.

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

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

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

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

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

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

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

21 A. No, I was not aware of that.

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

25 MR. BODIE: You mean 26th?

1 MRS. GARSON: 27th.

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

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

6 A. He was admitted on the 27th, I saw him on the
7 28th. I saw him the next morning, he was admitted
8 in the evening, I saw him in the morning.

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

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

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

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

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

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

1 MR. BODIE: Other than what
2 you have dictated?

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

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

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

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

17 A. No.

18 Q. Why is that?

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

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

1 appendicitis attack?

2 A. They could be consistent with appendicitis as
3 well as other things.

4 Q. What other things?

5 A. They could be consistent with a number of
6 things. Diverticulitis, they could be consistent
7 with colitis. They could be consistent with
8 adenitis. It could be consistent with Crohn's or
9 ulcerative colitis, some other things that are even
10 less prevalent.

11 Q. When you did your physical exam of
12 Mr. Baldwin, some of your findings were right lower
13 quadrant tenderness at McBurney's point and mild
14 rebound; is that accurate?

15 A. Can you repeat that?

16 Q. When you did your physical exam of
17 Mr. Baldwin the 28th I guess it was.

18 A. Yes.

19 Q. Some of your physical findings were right
20 lower quadrant tenderness at McBurney's point and
21 mild rebound; is that accurate?

22 A. Yes.

2.3 Q. What were your initial impressions based upon
24 these findings?

25 A. Based upon those findings and everything

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

3 Q. Okay.

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

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

11 A. Yes.

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

15 A. Yes.

16 Q. What is a mesenteric adenitis?

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

19 Q. What is the clinical picture for mesentery
20 adenitis?

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

25 Q. Let me ask you how do you distinguish between

1 mesentery adenitis and appendicitis when ruling out
2 your differentials?

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

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

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

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

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

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

18 Q. What do you mean by that?

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

1 Q. What are you watching for?

2 A. Watching to see how the patient does, does he
3 progress, does he get worse, does he get better,
4 that is primarily what you are watching. You're
5 assessing a number of things.

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

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

16 MR. BODIE: At what point
17 in time?

18 Q. On the August 27th admission?

19 MR. BODIE: Throughout the
20 whole admission?

21 Q. Yes.

22 A. You mean between the time he was admitted and
23 discharged? Yes..

24 Q. Yes what?

25 A. Yes, there was a determination that it was

1 adenitis, as opposed to --

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

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

8 MR. BODIE: Objection,
9 asked and answered.

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

14 A. Meaning is there some test or some --

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

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

22 Q. Yes.

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

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

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

7 A. Well --

8 MR. BODIE: Objection,
9 form.

10 A. It's a clinical impression mostly.

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

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

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

18 A. Well --

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

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

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

25 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

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

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

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

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

11 A. Yes, I did.

12 Q. What did you order?

13 A. Initially --

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

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

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

20 A. A CBC, chemistry profile, urinalysis, culture
21 and sensitivity, then a liver profile, amylase,
22 chest x-ray, another CBC later on. I believe he
23 had had abdominal x-rays that were done in the
24 emergency room so that was --
25

1 Q. Does the CBC, do the results of the CBC
2 assist you in ruling out appendicitis in this case?

3 A. Yes.

4 Q. In what way?

5 A. Well, almost always in appendicitis you have
6 an elevated CBC. When you don't see an elevated
7 CBC that tends to make you much less suspicious of
8 appendicitis.

9 Q. Even though you already testified here today
10 that not having an elevated CBC doesn't necessarily
11 rule out appendicitis, correct?

12 A. I would never say that a normal CBC would
13 rule out appendicitis.

14 Q. Did the liver enzymes testing help you or
15 assist you in ruling out appendicitis?

16 A. They assisted me in the scope that they were
17 negative. If they were positive -- that is
18 something that you would look at if it was positive
19 certainly.

20 Q. The normal liver enzyme testing you did does
21 not rule out an appendicitis, correct?

22 A. No.

23 Q. The chest x-ray, that doesn't help you rule
24 out appendicitis, does it?

25 A. Everything helps you a little bit in ruling

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

7 Q. What is that?

8 A. Surgically.

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

11 MR. BODIE: Let me object.

12 I think that is better addressed to a general
13 surgeon.

14 A. That was going to be my answer.

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

18 A. That is the only way you can know
19 100 percent, yes.

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

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

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

1 A No, it's not unusual

2 U It's probably more common for someone with a
3 retrocecal appendicitis to have a normal abdominal
4 film?

5 A. Are you telling me?

6 U I'm asking

7 A Sounder like you were telling me

8 Ho we absolutely honest, I don't
9 know that that is true Appendicitis can present
10 with a normal abdominal x-ray. So I would suspect
11 that a retrocecal appendicitis could also present
12 with a normal abdominal x-ray

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

15 A Which one?

16 Q I'm sorry, are there any diagnostic tests
17 that would assist in ruling out an appendicitis?

18 A. There are other diagnostic tests that could
19 assist.

20 Q. What are those?

21 A Other than what I mentioned?

22 Q. Um-hum.

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

24 Q Did you consider ordering a CT scan for

25 Mr. Waldman on August 27th of 1990?

1 A. I didn't see --

2 Q. August 28th or during his hospital stay?

3 A. Yes, I considered it.

4 Q. You decided not to order it?

5 A. Yes.

6 Q. Why was that?

7 A. Primarily because of his clinical picture.

8 Q. Tell me what you mean by that.

9 A. Meaning that he improved, he improved
10 rapidly, it was very quickly becoming apparent that
11 this was not an appendicitis.

12 Q. At what point did you consider and decide
13 against the abdominal CT?

14 A. Well, I don't remember the exact point in
15 time.

16 Q. Was it when you were thinking --

17 A. I never considered it strongly because when I
18 saw him the first time he was not -- surgery was
19 not an eminent thing. I generally would not order
20 a CT scan unless I thought there was a strong
21 indication for it, I didn't feel there was a strong
22 indication for it at any point.

23 Q. What is the indication **for** doing a CT scan to
24 rule out appendicitis?

25 A. To be frank, again, number one, I'm not a

surgeon.

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

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

23 A. Yes.

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

1 possibility here; is that true?

2 A. When I ordered the consult for a surgeon,
3 surgery was a possibility.

4 Q. What led you to believe that surgery was a
5 possibility?

6 A. Well, when you are thinking that when
7 appendicitis -- when acute appendicitis is in your
8 differential diagnosis, you have to think of the
9 possibility of surgery, that goes hand and hand
10 with it.

11 Q. If you were thinking the possibility of
12 surgery you said that was a situation where you
13 would order a **CAT** scan, right?

14 A. I said if I thought surgery was imminent.

15 Q. Not the possibility but imminent?

16 A. Yes, if surgery was likely. Frankly, as I
17 said, I don't order CT scans for the abdomen, that
18 is generally the surgeon's --

19 Q. What about ultrasounds, are those diagnostic
20 or helpful in diagnosing or ruling out
21 appendicitis?

22 A. Again, this is really out of my area of
23 expertise. In my experience, this may **have** changed
24 since then, at that point in time, ultrasounds I
25 don't believe were being used a lot to diagnose

--

1 acute appendicitis, I still don't think they are.

2 Q. What is done to diagnose acute appendicitis?

3 A. Generally it's a clinical impression.

4 Q. What about barium enemas, are those
5 diagnostic in ruling out appendicitis?

6 A. No.

7 Q. Why not?

8 A. As I said before, there is nothing that is
9 diagnostic in ruling out appendicitis.

10 Q. Not a barium x-ray?

11 A. It's not diagnostic, no. You can have a
12 normal barium x-ray with appendicitis too.

13 Q. Let's talk about the surgical consultation.

14 If I understood you or heard you
15 correctly, you were thinking, you were considering
16 appendicitis as a possible diagnosis, correct?

17 A. Yes, it was in my differential.

18 Q. Because you were considering or because
19 appendicitis was within your differential, surgery
20 was a possibility?

21 A. Yes.

22 Q. Because surgery was a possibility you called
2.3 in for a surgical consult; is that accurate?

24 A. Yes.

- 25 Q. Did you actually speak -- who did you call

1 in?

2 Dr. Sogocio.

3 Q. Did you actually speak with Dr. Sogocio?

4 A. At what point are you referring to?

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

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

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

12 A. At any point during the course?

13 Q. Yes.

14 A. Sure.

15 Q. Tell me what you remember.

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

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

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

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

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

1 page are you looking at?

2 MR. BODIE: 8-28 progress
3 note.

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

7 MR. BODIE: Can I take a
8 break?

9 -----

10 (Recess had.)

11 -----

12 BY MRS. GARSON:

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

15 MR. BODIE: He brought in a
16 surgical consult.

17 A. Correct.

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

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

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

3 Q. You examined him together?

4 A. Yes.

5 Q. At what time was that?

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

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

10 A. With Dr. Sogocio?

11 Q. Yes.

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

16 Q. Were those your words or his words?

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

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

20 A. It was an agreement, We totally agreed.

21 Q. It was an agreement between both of you?

22 A. Yes.

23 Q. Was it a.t that.,time on the 28th that a
24 decision was made to not conduct a surgery?

25 A. Yes.

1 Q. Whose decision was that?

2 A. It's the surgeon's decision whether to
3 conduct surgery or not.

4 Q. Did you agree with that decision?

5 A. Yes.

6 Q. You stated that you saw him on the 28th, at
7 that time the gist of it was it sure doesn't look
8 like appendicitis now, right?

9 A. Yes.

10 Q. What was the basis for that conclusion?

11 A. As I said before, the way the patient looked,
12 the way his symptoms, the way he felt, clinical
13 findings, just the overall picture.

14 Q. When was he discharged?

15 A. August 30th.

16 Q. Then you saw Mr. Baldwin, approximately from
17 August of 1990 through September of 1991?

18 A. I believe that is correct.

19 MR. BODIE: August 26th.

20 A. August 26 of '91, that's the exact date.

21 Q. Over that period of time when he came to see
22 you, what were his presenting -- his general
23 presenting complaints? Let's Look at the July 23,
24 1991 office visit.

25 A. July 23, 1991.

1 Q. I'm sorry, back up, you saw him on
2 September 7th of 1990?

3 A. 1990, yes, I did.

4 Q. Let's look at the office visit. When he came
5 to your office, what was the purpose of the visit?

6 A. It was a follow-up visit.

7 Q. Did he have any presenting symptoms at that
8 time?

9 A. No, he didn't.

10 Q. Did you conduct a physical exam?

11 A. Yes, I did.

12 Q. What were your findings?

13 A. He appeared healthy, his abdomen was benign,
14 meaning there were no findings, no lymphadenopathy.

15 Q. What is the significance of lymphadenopathy?

16 A. That means enlarged lymph glands.

17 Q. In any particular place?

18 A. Meaning primarily abdominal since that is
19 where his symptoms were.

20 Q. That was basically the follow-up with the
21 primary diagnosis that had been made in the
22 hospital of mesenteric adenitis?

23 A,... Yes.

24 Q. What was your assessment at that time?

25 A. That this was a resolved mesenteric adenitis.

1 Q. Is that unusual for mesenteric adenitis to
2 simply resolve on its own?

3 A. No, that is the clinical picture of
4 mesenteric adenitis.

5 Q. Did you do any blood work as follow-up for
6 the hospitalization?

7 A. Not as a follow-up for the hospitalization.

8 Q. Is there any reason why?

9 A. No, that's why I didn't, there wasn't a
10 reason why, he was better. Frankly, his blood work
11 in the hospital was normal. Since he was
12 completely resolved there was no reason at all to
13 obtain any other blood work.

14 Q. You saw him again July 23, 1991?

15 A. Correct.

16 Q. What were his presenting complaints at that
17 visit?

18 A. He had been having stomach pain for the last
19 two days, which he described as epigastric in
20 location. No nausea, vomiting, no diarrhea. He
21 had been seen again in the ER, they had discharged
22 him. Either they suggested that he see me again,
23 or he decided on his own, I don't recall exactly.

24 Q. What was your assessment as of that visit?

25 A. My assessment was he was suffering from

1 gastritis and possibly an ulcer at that point.

2 Q. What was the basis for that assessment?

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

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

13 Q.

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

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

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

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

25 Q. Right.

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

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

3 A No

4 Q Is there any particular reason why?

5 A It wouldn't have changed. Again, a doctor is
6 trained to make a precise base on what he sees.
7 what he finds.

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

13 MR BODIE: Objection. X

14 did not have point tenderness at the time he saw
15 him

16 MRS GARSON: It's not in his

17 office note, it's in his hospital record

18 MISS OLIS: X was

19 asking -- the question was asked in the present
20 tense, he wants you to remark if he had become aware
21 that he had point tenderness on July 22nd

22 MR BODIE: As opposed to

23 July 23rd. Your question assumes he did have a
24 point tenderness on the 23rd, there is no
25 indication he did.

1 Q. If you had been aware July 23rd that he had
2 had right lower quadrant point tenderness on the
3 22nd, would your assessment still have been
4 gastritis, rule out peptic ulcer?

5 A. Possibly not.

6 Q. Why not?

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

10 Can I make a suggestion?

11 MR. BODIE: No. Go ahead.

12 It's her opportunity to ask questions, Doctor.

13 THE WITNESS: I'm sorry.

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

16 A. August 6, 1991.

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

18 A. Yes, it was.

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

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

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

1 correct?

2 A. Yes.

3 Q. What was your physical exam or objective
4 findings?

5 A. My exam showed he still had tenderness in the
6 epigastric area, also in the right mid to lower
7 quadrants.

8 Q. Of what significance was it to you he had
9 pain in the right mid to lower quadrant?

10 A. Well, the significance was he had pain, I
11 don't know that I attached any special significance
12 other than that.

13 Q. You didn't at that time renew your suspicion
14 of a possible appendicitis, did you?

15 A. No, I didn't.

16 Q. Is right lower quadrant pain consistent with
17 peptic ulcer disease?

18 A. It can be.

19 Q. At this point you ordered some additional
20 tests; is that correct?

21 A. Yes.

22 Q. What did you order and what was the purpose?

23 A. I obtained an upper GI' series, a gallbladder
24 ultrasound and the purpose was to determine if he
25 may have an ulcer, primarily to determine if he had

1 an ulcer or not

2 Q. What kind of an ulcer?

3 A A stomach or intestinal ulcer

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

6 A I don't have tabs xer's it is, upper GI.
7 I'll read the impression Mild thickening of the
8 duodenal bulb, small pattern, intermittent spasms,
9 without discernible ulcer crater.

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

12 A What was normal.

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

15 A Well, my conclusion was that it was probably
16 a duodenal ulcer, or one in the morning where was
17 thickening of the duodenal bulb, which is the first
18 part the duodenum. Intermittent spasms, not a
19 definite ulcer crater, it's suspicious of infection
20 or inflammation, possible ulcer, early ulcer.

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

23 A It can be.

24 Q In what circumstances?

25 A Under any circumstances. You can have pain

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

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

6 A. The objective findings?

7 Q. Um-hum.

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

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

13 A. No.

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

17 A. Yes.

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

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

24 Q. That's all I meant.

25 A. I wouldn't make any comment further other

than I'm aware of that diagnosis, yes.

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

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

10 MRS. GARSON: I know.

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

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

22 MR. BODIE: Absolutely.

23 MISS KOLIS: Fair enough.

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

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

3 A. No.

4 Q. Fine.

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

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

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

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

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

25 Q. What time frame would you say is a chronic

1 abscess?

2 MR. BODIE: Objection.

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

5 Q. You are unable to answer that question?

6 A. Yes.

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

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

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

13 A. I saw no findings of an abscess whatsoever.

14 Q. What are the findings of abscess?

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

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

20 Q. For?

21 A. For abscess at all?

22 Q. For ruptured appendix and abscess?

23 A. No, I don't.

24 MRS. GARSON: Let me see you
25 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-l-e.

Q. What is Dr. Behrle?

A. A gastroenterologist.

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

1 A. He saw his partner, Dr. Padda.

2 Q. Are you aware of what the results of that
3 consultation was?

4 A. Yes.

5 Q. What was it?

6 A. You want just the results, is that what you
7 are asking me?

8 Q. Sure.

9 A. Assessment, symptoms consistent with
10 duodenitis, gastritis.

11 Q. Let me ask you, Doctor, does that assessment
12 give you an adequate explanation for this
13 gentleman's right lower quadrant pain he had since
14 the first admission to Flowers in August of '90?

15 MR. BODIE: Objection.

16 There is no indication that he had this ongoing
17 problem.

18 Q. I'm not going to say he had it every day. On
19 repeated occasions it is documented Mr. Baldwin had
20 a right lower quadrant tenderness, in August
21 of 1990 through September of 1991.

22 My question to you is: Did this
23 diagnosis of duodenitis and gastritis, was that a
24 satisfactory explanation for you?

25 A. It was a satisfactory explanation for me as

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

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

5 A. At what point?

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

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

11 Q. Please do.

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

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

25 At that point I zeroed in on that,

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

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

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

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

21 MR. BODIE: Objection.

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

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

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

4 A. When was this one again?

5 Q. This is in August of '91.

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

10 A. Not necessarily, no.

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

13 MR. BODIE: We will
14 reserve.

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

20 MR. BODIE: Great.

21 -----

22 (Deposition concluded; signature not waived.)

23 -----

24

25

ERRATA SHEETNOTATIONPAGE / LINE

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

.....

MARK E. REARDON, M.D.

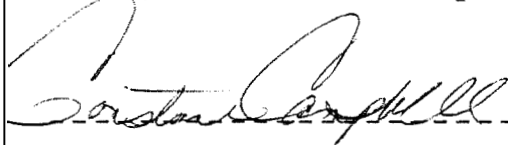
1 The State of Ohio,
2 County of Cuyahoga.

CERTIFICATE:

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

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

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

21 
22 -----

23 Constance Campbell, Stenographic Rep
24 Notary Public/State of Ohio.

25 Commission expiration: January 14, 1998.



Look-See Concordance Report

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

SINGLE FILE CONCORDANCE

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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**

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