MC GINNIS & ASSOCIATES, INC.
COLUMBUS, OHIO (614) 431-1344

IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

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Bertha Fisher, Plaintiff,	)	
vs.	)	Case No. 323197
Amitabh Chak, M.D., et ai.,	)	Judge Michael Corrigan
Defendants.	)	

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Deposition of Richard E. Schlanger, M.D., Ph.D., a Witness herein, called by the Defendants for Examination under the statute, taken before me, Rose Marie Prater, Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel without notice or other legal formality, at the offices of the deponent, 1492 East Broad Street, Suite 1300, Columbus, Ohio, on Wednesday, October 22, 1997, beginning at 2:00 o'clock p.m. and concluding on the same day.

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APPEARANCES:

ON BEHALF OF THE PLAINTIFF:

Donna Taylor-Kolis, Esq.
1370 Ontario Street, Suite 330
Cleveland, Ohio 44115
(216) 861-4300

ON BEHALF OF THE DEFENDANTS:

Markus B. Willoughby-Sjogren, Esq.
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue, Suite 1600
Cleveland, Ohio 44114-1192
(216) 736-8600

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S T I P U L A T I O N S

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It is stipulated by and between counsel for the respective parties herein that the deposition of Richard E. Schlanger, M.D., Ph.D., a Witness herein, called by the Defendants for Examination under the statute, may be taken at chis time and reduced to writing in stenotype by the Notary, whose notes may thereafter be transcribed out of the presence of the witness; that proof of the official character and qualification of the Notary is waived; that the witness may sign the transcript of his deposition before a Notary other than the Notary taking his deposition; said deposition to have the same force and effect as though the witness had signed the transcript is of his deposition before the Notary caking it.

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I N D E X

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RICHARD E. SCHLANGER, M.D., Ph.D.

of lawful age, being by me firsc duly placed under oath, as prescribed by law, was examined and testified as follows:

EXAMINATION

3Y MR. WILLOUGHBY:

Q. Hi, Doctor. My name is Markus Willoughby, a x-1 represent Dr. Amitabh Chak, A-m-i-t-a-b-h, C-h-a-k, in a medical negligence case chat Bertha Fisher has brought against him. It's my understanding that Donna Kolis has hired you to render criticisms against Dr. Chak for his care and treatment of Bertha Fisher; is that correct?

A. That's correct.

Q. I have been provided a copy of your CV, and I want to show it to you here and ask you if that's an updated copy. I gave the same copy to your counsel -- I mean to Donna.

As you're looking at that, I'm going to have a copy -- Well, I'll ~ a i ~ .

A. Take this one instead.

(Handed.)

Q. Is it updated?

A. Yeah.

Q. What's the difference between these two?

A. There's a couple of both -- either on academic appointments and/or committees, just a couple of things that have been deleted or added, just little things.

You'll find one on the page under "Research: Development" for U.S. Medical Corp., there's one that says "Physicians Advisory Board" for the State of Ohio, Region IV, where I was teaching EMS and doing trauma for Governor Voinovich.

Q. Anything else that's different?

A. No. Pretty much everything else is the same, but i thought you'd like to have that.

MR. WILLOUGHEY: I'm going to go ahead and have that marked as Defense Exhibit A.

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Thereupon, Defendants' Exhibit A was mark& for purposes of identification.

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BY MR. WILLOUGHBY:

Q. Do you have another copy?

A. Actually, I can get another copy, if you like.

Q. Why don't you take a lock at that?

A. That's the one thac I gave you.

Q. Yeah, I know. We marked it as an exhibit; so it's going to be attached to the deposition so everybody will have a copy of it.

A. That's fine. Okay.

Q. Do any of the entries on your CV address the specific issues involved in chis case; that is, either a microperforation or perforated colon or delayed perforation?

A. I don't think so, no.
Q. Looking at your curriculum vitae, you did undergraduate at Hofstra University in New York?
A. Not exactly. I did undergraduate at Tulane University in Louisiana, and did postgraduate work at Hofstra University in New York.
Q. Okay. Where did you get your M.D.?
A. M.D. was at the University of Toulouse in France along with my Ph.D.
Q. Why did you go to France to get your M.D.?
A. Basically this was 1973, '74, when the end of the Vietnam War was producing a vast number of people trying to still get out of the draft. I made 15 waiting lists, and at the end of, I guess it was, September when I still hac not heard significantly, I had run into a French cardiovascular surgeon who said "Why don't you come overseas, work with me, and go to medical school"; so I did.
Q. You received a Ph.D. in immunology?
A. That's correct.
Q. You came back and you did a flex program, which is essentially a one year -- Why don't you tell us wnat a flex program is?
A. Basically the flex is a licensing examination chat is in competition with the National Board of Medical Examiners. People that do not go to U.S. medical schools cannot qualify for

I the National Medical Examiner's Board, and the flexible program
2 is a way of gaining a national licensing possibility.
3 What I did do when I returned from overseas is amended a
a flexible internship program at Mt. Sinai Medical Center. This,
5 instead. of doing just one specialty, I did pediatrics, emergency
6 room, internal medicine, psychiatric rotations, OB-GYN and
surgery.
8 Q. Which would be approximately equivalent to an internship
9 year for a person coming out of medical school?
10 A. That's correct.
11 Q. You did another internship in the field of surgery?
12 A. Yes, that's correct, at Ohio State.
13 Q. It was at Ohio State, along with *your* residency as well as
14 Ohio State?
15 *A*. Thae's correct.
16 Q. When did you finish your residency?
17 *A.* 1986.
18 Q. And then did you sit for the Board?
19 A. Yes, I did.
20 Q. Did you pass on the first attempt?
21 A. Yes, I did.
22 Q. It says here American Board of Surgery, certified in 1988;
23 is that a misprint?
24 A. No.
25 Q. Why did it cake two years --

A. Well, basically I did not take them the first year out because of work here. I went into private practice, and it just became very difficult. But the other thing that I need to tell you is I passed the written the first Lime, and chey were backlogged and asked if I could take the written not in the '87 year, but the first available '88 year, and that's why It was delayed that much.

Q. So you took the orals in '87?

A. No, I took the written in '87, my first year out as eligible, and took the orals in '88.

Q. Okay. And chat was because chey asked you to?

A. They asked as it was a convenience, they were overlapped, and I thought I could use a little bit more time.

Q. Sure.

A. So I took them a year later.

Q. You were board certified in surgery in 1988 then?

A. That's correct, and recertified in '96. It doesn't have it on there?

Q. No, it dces not.

A. Oh, it should. Yeah, I've recertified.

Q. You're not board certified in internal medicine?

A. No.

Q. You're not board certified in gastroenterology?

A. No.

Q. When were you first contacted to review this case?

A. I can't even begin to tell you. It's been a while.
Q. All right.
A. It's more than six months.
Q. Did Donna contact you directly?
A. Yes.
Q. She didn't go through a service?
A. I don't go through services.
Q. Did she give you any particulars over the phone as to what this case was about?
A. I think she may have just told me a little biz about it, which was a colonoscopy patient developed some problems, would you look at it.
Q. And she followed up with some correspondence?
A. Basically sent the records, and I looked at the records. Now, I'm going to tell you "Less are hers, Mine are in Chicago.
Q. Okay.
A. I reviewed -- I was in Chicago over the weekend, reviewed everything there, and accidentally left them and they're being shipped down.
Q. Okay. Do you know what it was that you reviewed, because it is not specifically identified in your report?
A. Well, basically wnat I did review are the colonoscopy record, which was an outpatient procedure, and her inpatient hospitalization.
Q. Which inpatient hospitalization?

A. Well, the original, which was the 4-21 through 5-1-96, and then there are some subsequent admissions for other problems, but that was the main thrust of my study, was to see what happened after she came in with the perforation.

Q. Have you ever been involved as a part;. or a witness in any lawsuit that involves a perforated colon?

A. I believe I did two cases for PIE about two years ago that dealt with a perforated colon. Somehow the name Abramson comes to mind as one of the cases, and I jusc can't remember the name of the other, but I chink those were the two chac I do remember.

Q. Did you give deposition --

A. I gave depositions for PIE in these cases.

Q. -- in both of those cases?

A. Yes.

Q. Were those cases in Columbus or were they in some other city?

A. They were from outside of central Ohio, but they were Ohio

Q. Were both of these cases approximately two years ago?

A. I would suspect.

Q. Have you ever reviewed a case for Donna in the past?

A. Just one other that I think we're working on now.

Q. After you produced your report dated July 12th, 1996, whac records did you review, any additional records?

A. No.

Q. Did you review -- You've not reviewed the deposition of

Dr. Chak?
A. That came very recently.
Q. Have you had a chance to Look at it?
A. Yes.
Q. Ail right. Did you review the deposition of Bertha Fisher?
A. I have not seen Bertha's deposition.
MR. WILLOUGHBY: Off the record.
(Discussion held off the record.)
MR. WILLOUGHBY: On the record.
BY MR. WILLOUGHBY:
Q. Have you reviewed the expert report of Dr. David Lieberman?
A. It was just a one-page report or two-page report that I received very, very recent;Y.
Q. Did you have a chance to review it?
A. Yes.
Q. Any other records that you've received?
A. No.
Q. ass your review of Dr. Chak's deposition or Dr. Lieberman's CV changed your opinion in any way?
A. No.
Q. I'm going to 'nand you what I received from Donna Kolis, wnat I believe to be a report written by you to Donna Kolis regarding the care rendered by Dr. Chak to Bertha Fisher?
A. If I could have just a second to reread it.
Q. Please.

(Witness reviewing documents.)

A. Okay. Yes, it has the appropriate misspellings that I'm noted for, yes.

Q. It sort of identifies it, huh?

A. Yes.

Q. Is this your only report that you've authored in this case?

A. Yes.

Q. You have not written a supplemental report?

A. No.

MS. KOLIS: Would you like one? No, I'm kidding.

BY MR. WILLOUGHBY:

Q. How many hours have you spent reviewing the materials in this case, total for this case, phone calls, not including this deposition, though?

A. Oh, probably somewhere between six and seven hours.

Q. How much are you charging an hour?

A. I am going to --

Q. While you're at it, why don't you give me a breakdown for how much you charge for review, for depositions, for trial?

A. You Seat me to it.

Q. Sorry.

A. We are a practice of three surgeons. When I got here, my two partners, who do significant amount of legal work, had preset what Surgical Associates of Columbus charges; so it's the same for all three of us.

Chart review, telephone, written report, $250 an hour; deposition and preparation, $500 an hour; depo cancel within 48 hours, $500; trial out of town, 3,500 a day; in town, no more than half a day, $2,500; trial cancellation within a week of trial, $1,000; video deposition, $1,500.

Q. Is it your intention to appear live ac chis rial?

A. Yes.

Q. Have you taken a day off so that ycu can travel up to Cleveland?

A. Well, if it's been scheduled, most likely what will happen is that day will have already been blocked out.

Q. Ail right. Are the opinions that you plan on rendering at trial outlined in this report?

A. Somewhat, yes.

Q. Do you have any --

A. In other words, I -- depending on your questions and 'now they come across, they may be slightly syntactically different, but pretty much.

Q. But based on your review of the records, this expert report accurately defines or sets forth an outline of your criticisms?

A. Yes.

Q. Do you have any other criticisms that are not contained in chis report?

A. I don't believe so.

Q. Have you been asked to review any additional material after

chis deposition but before the trial?
A. Not that I know of.
Q. Can you give me a breakdown of your practice in terms of how much time is spent in different areas in which you practice?
A. Approximately 85 percent is clinical and direct patient care, 5 percent is purely administrative, and the remaining 10 percent is either research or dealing wich some form of clinical product evaiuation.
Q. And that 10 percent, do you include literature that you've authored?
A. About half, yes.
Q. Where do you put the other half?
A. The other half is product evaluation, being asked to participate in the clinical trials of new instrumentation or new theoretical devices.
Q. How much of -- Strike that.
How many diagnostic colonoscopies do you perform in a month?
A. Myself, maybe one, but I'm present at no less than 15 to 20 while it's been done by my gastroenterologist.
Q. In a Leaching setting?
A. Well, they're doing it, and I'm down there with my patient watching the exam going on, or maybe three to four times a month we're doing an operative case in which a gastroenterologist is present in the OR physically performing the colonoscopy while I

I have been over him.
Q. So you're present for around 15 to 20 colonoscopies a month?
A. I would suspect chat's accurate.
Q. And has that practice remained. constant for the past five or so years?
A. Yes.
Q. ■ want to ask you some general questions about the medicine in this case and about the care that was rendered. First, can you tell me what the layers are of the cecum wall?
A. The cecum being part of most of the colon, there is a mucosa, a submucosa, a muscularis, an outer serosal wall and then what we call a ratty layer jusc outside, pericolic fat.
Q. What is the mucosa?
A. Mucosa is a velvety covering; that has the glandular structures. It's a fairly thin, usually lumpy, bumpy filled with villi that is the absorptive area for the colon.
Q. And what is the submucosa?
A. The submucosa is the strength layer. It is a fibrous mix of both connective tissue and some loose muscle, which is the layer that we achieve our sutures through to make our anastomoses; that is the strength layer of the colon.
Q. What is the muscularis?
A. Muscularis is either a circular or longitudinal muscle which make for the contraction of the peristalsis of the colon.

Q. And, I'm sorry, what were the other layers?
A. You have a serosa and pericolic fat.
Q. Can you tell me what the serosa layer does?
A. The serosa is just an outer envelope, and it's usually covered with a peritoneal lining. It holds the integrity of the bowel together. Its function is almost like the outer layer of a muscle in itself, almost a fascial layer.
Q. What's it made out of?
A. It's just a serosal lining, usually one or two layers of monocells. it really -- I've never looked ac it under the microscope to tell you exactly what it is, but it's usually fibrous.
Q. What is the pericolic layer?
A. It's fat around the colon and usually will contain lymph nodes.
Q. How thick is the cecum wall normally on a normal person? I know there may be some variation, but if the need to be some variation in your answer, just give me the high, low end.
A. Most of the time when you cut through a normal cecum, we're calking maybe two to three millimeters in total thickness; it's not very thick at all.
Q. Do you know how chick the unulcerated area of Mrs. Fisher's cecum wail was?
A. Can't tell you.
Q. You didn't see that on the biopsy specimen that was done?

A. Well, I can look at that, but the thing is that's a fixed specimen; when they're fixed, they thicken up. The thing that a lot of people don't appreciate is once you've blown air into the colon, that thickness completely dissipates. We're talking paper thin. So even though this area may have had a certain thickness on pathology, and I can look at it and give you what they said, that's after it's fixed. The gross description, patient's fragment's .2 by .05 centimeters, which is the area we were talking about.

Q. That's not the 4-21-96 pathology report, is it?

A. Well, maybe it is. That's 4-19. Okay. I've got to find the other one; so scratch that. I don't have that.

Q. I might have that.

A. Let me see.

MS. KOLIS: It should be in the records that I gave you.

THE WITNESS: Well, let's see if you can find it because I'm not finding it right off the bat, unless I've missed it in here.

BY MR. WILLOUGHBY:

Q. It's not a very good read, but --

(Handed.)

I think you'll find it in that description.

A. The cecal wall thickness ranges from .5 to .005. That's kind of hard for me to really see that he was able to make that

determination with a magnified scope.
Q. Do you have any reason to disagree wich the pathologist's estimation as to the thickness of the cecal wall?
A. Well, the estimation, again, it's not full thickness, and he is looking at a punch biopsy that has been put in formalin; it's not a frozen section.
Q. He was looking at a punch biopsy?
A. If this is -- Have you ever taken a biopsy with an endoscope?
Q. Not myself, no.
A. You have to understand that he's putting in a scope that's probably a little bit bigger than my finger and through that channel he's putting in a one, maybe a half a centimeter chick wire. And at the end, he's got a little punch that he takes a bite. That's how the biopsy is done. These are infinitesimal pieces, and it's very hard to estimate exactly what they are, they're tiny,
Q. I don't think thac's a biopsy. I think it's a specimen.
A. This is a surgical specimen and, again, chis has been fixed.
Q. What do you mean when you say "fixed"?
A. It's been put in formalin. And I go down and look at all my pathology specimens fresh, and when I look at the pathology specimen fresh, when I've cut it, it bunches up and it locks thicker than it actually is. Then when we put it in the

formalin, it's like it's Seen canned, and chis thing is rigid. And I found they significantly overestimate the thickness of the cecum.

Q. Are you aware of any literature to suggest that when a specimen is placed in literature (sic) it expands?

A. You mean in formalin?

Q. I'm sorry, formalin.

A. It thickens. I can get -- I'll talk to my pathologist and see if there's anything, but I've always noticed that.

Q. I would appreciate receiving thac information.

A. Well, he says the colonic wall, as we talked about, was .5 in an uninvolved area and very chin, .05, in the ulcerated area, which is paper thin.

Q. If you have a denuded area, say the size one centimeter square, in the cecum such that only some or all of the mucosa with none of the muscularis or submucosa was gone, would you expect the wall of the cecum to be intact?

A. I can't answer that a hundred percent. If this is done during a colonoscopy and this is a traumatic area, I would say with all -- within medical probability, that's a full thickness perforation.

Q. I'm sorry, I'm not sure I --

A. You've asked if this was an area of denuded, that he talks about as being traumatic.

Q. I just asked you a hypothetical.

A. Okay. Hypothetically, again, if it's during a colonoscopy and the area is fibrotic and looks as a true ulcer, chances are it's not full thickness. But if it is a split, there is more than a reasonable doubt that It could be possibly full thickness. These are scopes thac are front-viewers, not side-viewers; so they don't get a full, direct visualization of these areas. And being there and seeing enough of these, I watch them maneuver and trying to get head-on on something that may not be directly in front of them. It's almost impossible. Only with a side-viewing scope could they make that determination.

Q. Let me ask my question again.

A. Please,

Q. Because I think maybe we sort of got sidetracked.

A. Okay.

Q. If you have a denuded area approximately the size of one centimeter square --

A. Right.

Q. -- in the cecum such that some or all of the mucosa, but none of the submucosa and none of the muscularis was gone, would you expect the wall of the cecum to be intact?

A. I would expect tnat to be intact, yes.

Q. How significant is mucosa in maintaining the integrity of the cecum wall?

A. The xucosa itself is fairly important, but it's the

submucosa which is the most important area, but chances are you can't tell the difference when you're looking whether or not you're seeing submucosa or muscularis.

Q. On using the scope or --

A. Using the scope.

Q. Okay. But on pathology, you could see it?

A. Pathology, they should be able to tell you what they're looking at completely.

Q. Are you familiar wich the terms "hot" and "cold" biopsy?

A. Yes.

Q. Can you tell me what they are, the difference between those two?

A. Hot biopsy is the biopsy machine is connected to an electric source of some kind that's going to allow the area to be coagulated. They're either going to be using a wire or a punch that the force generator will not only cut through the mucosa but, hopefully, create a coagulated stock.

The cold biopsy is putting this punch in, taking a cold piece; thank you very much.

Q. is any one associated with a higher risk of perforation than the other?

A. The hot biopsy usually has a higher risk.

Q. Do you know what the incidence of perforation is in the diagnostic laparoscopy without biopsy?

A. You mean diagnostic colonoscopy?

Q. Colonoscopy.
A. Yeah, we're talking in less than one to two percent. It's a very low number. It's usually only a higher number in patients that have had multiple surgeries. The patients that are known to have the disease entity such as an ulcerative colitis, diverticulitis, or a cancer in which we're dealing with a perforated bowel, or if we know there *is* ulcerations after ulcers, herpetic ulcers, or patients that have AIDS, that we find ulcers in the area of the cecum.
Q. Do you know what the incident of perforation is in a colonoscopy with cold biopsy?
A. Again, it depends on what we're biopsying. If it's a polyp that has a long stalk, it should be less than a tenth of a percent. In ulcerated lesions, I think we're close to 3 to 5 percent.
Q. What's the risk of incidence of perforation in a diagnostic colonoscopy with hot biopsy?
A. It probably goes up to 7 percent, especially with loop.
Q. What is a microperforation?
A. Basically it's -- Most endoscopists would like to -- when there is a perforation, would like to be able to see the perf, but if there is an area where either from the trauma or biopsy the actual perforation is only as big as the biopsy specimen and doesn't manifest as this huge spontaneous hole that you can drive the scope through, there is leakage of air into the

peritoneal cavity, and this should produce the typical subdiaphragmatic crescent of free air.

Q. Over what period of time?

A. Well, the amount of air that's put into these colonoscopies, especially in the cecum, it should be within anywhere from 15 to 20 minutes to an hour, to two hours that the patient will manifest either pain, bloating, and you'll have a positive X-ray.

Q. Are you familiar with the term "delayed perforation"?

A. Yes.

Q. What is that?

A. Delayed perforacion is when there has been a mini perf or a smaller perforacion that was missed, and as the bowel continues to peristals, it denudes even further, and you have a very large perforation 24 to 48 hours down the road.

Q. Do you chink that's what happened in this case?

A. No. Well, in effect, *yes* and no. I chink she had a microperforation, and it finally manifested as a full-blown perforation 48 hours later; so yes.

Q. 30 you know how large thac perforation was when she came in on 4-21?

A. I think at the time of surgery, a centimeter ana a half to two centimeters in the cecum.

Q. If a person has a delayed perforation, does that mean that the person that performed the colonoscopy was negligent?

A. They can happen. The key to my opinions in this is that I feel his description of traumatic denuded areas and then biopsying them probably caused the microperf and seeing that as a traumatic injury. If he had taken the precaution of just doing a simple flat plate before she left that day, they would have picked it up.

Q. I appreciate that, and we're going to talk about that in a few minutes.

A. Right.

Q. But I think my question was: If a person has a delayed perforation, does that mean that the person who performed the colonoscopy was negligent, that in itself?

A. That, in itself, it depends on if there was something done to provoke the microperf, which then caused the delayed perforation. If someone is doing a standard colonoscopy, finds that --

Q. I'm asking -- I think my question is a delayed perforation in itself. Just because you have a delayed perforation does not necessarily mean that you have negligence, does it?

A. I think I can't answer that question directly. I think what I'm trying to say -- and, you know, we can go around; we'll correct this some way.

In itself, in a standard, nontherapeutic colonoscopy, a delayed perforation can happen. But if a colonoscopy is done and there's a therapeutic maneuver and a delayed perf happens,

I've got to reserve my opinion depending on what that therapeutic maneuver was. And that's basically how I'm going to have to answer the question.

Q. Fair enough. That's fair enough. Have you ever perforated a colon during a colonoscopy?

A. I have not, but i have been present during one when my gastroenterologist did it, and we took the patient immediately to the OR.

Q. Have you ever performed a colonoscopy on a patient who later on, down the road, complained of a perforated colon?

A. No. I have been very lucky, and that's a fact.

Q. Do you have Dr. Chak's operative note there? I see it's highlighted.

A. I have the colonoscopy note.

Q. Okay. You see there it says In the clinical note thac there's a "57-year-old lady with two out of six samples showing occult blood, digital rectal exam was normal." And I -- can I assume that you agree that the colonoscopy was warranted?

A. *Yes.*

Q. It goes on to state "Advanced colonoscope to the cecum, found focal hemorrhagic areas." He watched it, found a round denuded area with muscularis visible through denuded mucosa?

A. Right.

Q. Okay. You would agree with me that from this record, it appears that not all the mucosa in the denuded area was missing?

A. Well, I think what he says is in the denuded area there is no mucosa.

Q. It says denuded nucosa and that the muscularis was visible through it. Does that suggest chac the mucosa was absent to you?

A. In that area, yes.

Q. Would you think Dr. Chak was interpreting his own writing incorrectly if he were to say that chis statement does not represent the absence of mucosa?

A. Well, if he's saying thac, then he's describing something that I can't understand, When you have an area chat is denuded -- "denuded" in itself means there is a layer missing. So he's found an area where there Is no mucosa, but that the muscularis, he feels, is visible.

Q. Denuded means missing?

A. In my opinion, yeah.

Q. Can it mean something else?

A. Not thac I know of in my medical practice. When I say something has been denuded, it's been deleted, it's gone.

Q. It goes on to say thac the etiology of the lesion was unclear but may be traumatic?

A. Correct.

Q. Would you agree with me chat from this record, it appears that Dr. Chak was unsure whether it was related to air or insufflation or some underlying process?

A. I agree with that.
Q. Based on your knowledge and experience, can you tell me what the possible causes of this denuded area were?
A. Well, since he found no exudate and no fibrous buildup or anything that I would describe as a true ulceration, I would agree with his appraisal, this could have been traumatic.
Now, "traumatic" to me, from chis, was most likely scope induced. E don't know what ocher zrauma chat you could pinpoint on this.
Q. Would air insufflation?
A. Well, chat's part of the trauma of the scope, either the scope doing It or just overinflating that area.
Q. When there's a trauma as a result of air insufflation, how does the injury occur?
A. Basically, if we talk about something other than colonoscopy, but we're talking about an obstructing colon cancer, there is air that is then passed through the colon, and the ileocecal valve in some cases is so competent that there's no reflux of gas into the small bowel. Therefore, the cecum, being the most dependent point of the colon, will expand. The critical size is 14 centimeters. At chac point, the mucosa rips, the submucosa, the muscularis, until finally you get a Cull-blown perforation.
Q. The perforation starts from the inside out or the outside in?

A. Inside out, because you're blowing this way (indicating); so you're stretching all the inner layers, and each one in turn, its integrity is lost. You may at a critical point have a split in the serosa, which is the outer envelope, simultaneous, and that is an outpatching of the mucosa, and that finally splits. it ail depends on how much insufflation is performed.

Q. Just so I'm clear, you are able to rule out, to a reasonable degree of medical certainty, any other process thac might have been going on with this patient except for trauma?

A. From the fact that he found these areas that washed off easily and saw no other true sign of Oddi colitis, a polyp or anything else, it sounds like this, to my knowledge and reasonable medical probability, is a traumatic injury from either air insufflation or passage of the scope.

Q. If you were still unsure as to that, would it have been beneath the standard of care not to biopsy that area if she would have had some underlying process?

A. i would have tried to biopsy something else. I would not have gone to an area that I thought *was* a trauma. Since I have effaced it, flattened it and made it very thin, I would nave been very afraid.

Q. By the way, what ares **did** Dr. Chak cake a biopsy from, do you know?

A. Well, he says these areas were biopsied.

Q. Do you know where that area was that 'ne biopsied?

A. He doesn't say, but I'm suspecting it's one of the denuded areas.
Q. Could you tell from his deposition after you read it?
A. I -- It's still a little confusing when I read it, I'm not sure what he was talking about.
Q. If he -- If you or some physician were going to biopsy chis area, what area would be the safest area to biopsy?
A. I would biopsy the mucosa next to the denuded area.
Q. Do you know that Dr. Chak did not do that?
A. There's no way from this record I know thac.
Q. If he did do that, would chat be within the standard of care?
A. It would. have been closer to the standard of care, yes.
Q. Would it have been within the standard of care?
A. i would suspect, *yes*.
Q. What are the signs a physician looks for in a -- in diagnosing a perforated color, after a colonoscopy?
A. Immediately after a colonoscopy the patient can have abdominal distension, the patient can be a little bit more uncomfortable, can have some diaphragmatic and shoulder discomfort, but there's nothing terribly specific immediately.

What needs to be is the suspicion that something could have happened or the area Is extra thin, or I jusc want to make sure everything's okay before I leave. It's a clinical suspicion more than an actual finding, unless I've pushed the scope

through and I know and I *see* the small bowel.

Q. Okay. If you have a clinical suspicion or your suspicion is raised because you saw a traumatic area or an area that may have resulted from trauma on the scope, do y o automatically a an X-ray, or do you look for signs?

A. No, I automatically do an X-ray.

Q. Is that the standard of care?

A. I believe from the general surgical population, those of us that see these and do these, I would say that would be the standard of care.

Q. Including gastroenterologists?

A. I can't talk for a gastroenterologist, but I *know* what my gastroenterologists here do. I mean, *we* see something like chat, that patient would have had a flat place just for KYA.

Q. Based on your review of the records, after [redacted] colonoscopy, before she went home, the recovery records, was there anything specific in chose records to suggest that Mrs. Fisher nay nave had a perforated colon?

A. Again, if it's a microperforation, she's not going to show much. *She* nay have some discomfort, but I looked at those very carefully and they weren't really way out of line. And again, that's part of the problem with a microperf. It's a clinical suspicion of what you saw at the time of your colonoscopy that would provoke you to get the X-ray.

Q. And if I understood you correctly earlier, you said chac: a

microperf will show free air in the abdomen 15 to 25 --
A. Twenty minutes.
Q. -- after the microperforation?
A. That's correct.
Q. And that is for all microperforations?
A. Well, you've got to remember you're putting in tons of air and it's like a little pin hole, like a hole in a balloon; it's leaking. It should snow up. That's a small crescent, and the patient may not be having tremendous symptoms at all, but the free air is there and that's the time to do something because they're fully prepared.
Q. At 20 minutes how much air would you see?
A. Maybe 50 to 100 cc's.
Q. When would a patient start experiencing symptoms?
A. Maybe within 24 hours.
Q. So in 20 minutes you've got 50 cc's of air. Would that be a constant flow of air?
A. Well, the colon really has not been decompressed totally; so there's still going to be air. You're also going to be having small bowel gas getting in there; so there will be air building up over the next hour, six hours, twelve hours. As the patient swallows, it's still going to be leaking air.
Q. I'm wondering how much air you'd see in the cavity if we checked in six hours?
A. It probably would be a good amount of a crescent, probably

a couple hundred cc's worth of air.

Q. Would you expect that a patient would not exhibit any symptoms at that point?

A. Again, air isn't an irritant. Stool is an irritant, GI content is an irritant, and since this patient at six hours still did not have full transit and had a perfectly clear colon from a liter -- four liters of GoLYTELY, there's still little contamination or irritant.

So what they're going to have is a little bit of abdominal distension, maybe a little discomfort, but nothing that would be out of the ordinary that would send the flag up within the first few hours.

Q. So at six hours you would not expect the patient to have any discomfort?

A. Well, they'll have post-colonoscopy discomfort; they may have increased gas.

Q. Abnormal discomfort?

A. Abnormal for a post-colonoscopy? Probably not.

Q. How long after a colonoscopy would you associate discomfort that's normally associated wich colonoscopy?

A. I've had discomfort up to a day, just soreness, depending on how much manipulation was done, And there were patients chat will have up to two days of discomfort if they've had multiple surgeries in the past.

Q. And you know from reading the records that Mrs. Fisher was

given specific discharge instructions for wnat to look for after her -- after she went home?

A. Yes, I'd like to reread those. I think they were pretty much standard. I have the flow sheet.

Q. I have a copy here.

A. Would you mind?

Q. Not at all.

A. Thank you.

(Handed.)

Right.

Q. Standard?

A. Very standard.

Q. Okay. Do you know when she contacted Dr. -- I'm sorry, were you finished?

A. I am finished.

Q. Do you know when she contacted Dr. Chak she first cfme --

A. There is no --

Q. -- after the procedure?

A. After the procedure, the only thing that I nave heard is that he called -- she called him about a day and a half later. Now, I have not read anything, but I have been told that she called him a day and a half later. I have not found anything in his records either, but apparently she did call him.

Q. She did call him.

MR. WILLOUGHBY: Off the record.

(Discussion held off the record.)

MR. WILLOUGHEY: Back on the record.

BY MR. WILLOUGHBY:

Q. Doctor, are you familiar with Ramsey score -- Ramsey score?

A. Not really.

Q. If I showed it to you, maybe it might --

A. Okay. It might be in somebody else's.

(Handed.)

And wnat are they measuring?

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

A. I don't know because I don't use the Ramsey score.

Q. It is a measurement of sedation.

A. Okay. And which I suspect ten would be the highest level of sedation? I have no idea because we don't use the Ramsey score.

Q. Four to six, I think, is deep sedation.

A. Okay. I don't use this in any of our procedures; so I'm not familiar with it.

Q. Okay. Can you tell me to a reasonable degree of medical certainty whac caused Mrs. Fisher's perforation?

A. I think the patient either had it from overinflation or one of the biopsies actually caused the microperf.

Q. Do you know whether it was the overinflation or whether it was the biopsy?

A. Can't tell exactly, but the clinical -- I have the path

report that I think is "Cecum biopsy, benign lymphoid aggregate. Focal area of hemorrhagic cecum, round area appears to have denuded mucosa."

So if I take this at its face value, it sounds like there was a denuded area of muscularis or something that was biopsied in one of the areas that I thought was super thin and that may, in fact, have caused a perf.

Q. So that pathology report gives you the message that the muscularis was biopsied?

A. Well, It doesn't say anything. It just says focal area of hemorrhage appears to have denuded mucosa. So chis path report really doesn't give me a whole lot to go on. I don't know what else they're talking about. The final diagnosis was "benign lymphoid aggregate," I don'c know where that's from.

Q. What does that mean?

A. Basically it's benign lymphoid tissue. Now, lymphoid tissue, unfortunately, is in the wall closer to the muscularis and serosa than anywhere else; so this is a really thin area.

Q. So that's an area that Is closer to the --

A. Outside of the bowel-

a. -- outside of the bowel than it is the mucosa?

A. Correct.

Q. But you don'c:know whether it was the air insufflation or the biopsy itself that had caused the perforation?

A. Well, you know, it's kind of a chicken before the egg.

I've overinflated, or I've performed some form of colonic scope injury, which has already given me an area that's stretched and now I'm taking a biopsy of that area.

Q. But you don't know where he took the biopsy from, do you?

A. Well, if it shows denuded mucosa, in other words, absence of, in my definition, it sounds like he took the denuded area rather than mucosa because they don't describe mucosal findings in the pathology; so I think my original interpretation of him taking the biopsy of the denuded area, per his report, is pretty close.

Q. But my question is: Can you tell me to a reasonable degree of medical certainty whether it was the air insufflation or the biopsy that caused the perforation?

A. I can't.

Q. Okay.

A. It's impossible.

Q. Okay. Do you know that perforation Is a complication of coionoscopy?

A. Yes.

Q. And you know that Mrs. Fisher was aware of that?

A. Yes, I do.

Q. Have you heard of the term "medical judgment"?

A. Yes.

Q. What does chat mean?

A. Based on a doctor's clinical skill, he'll make a decision

based on the clinical presentation.
Q. Have you ever Seen sued for medical negligence?
A. Oh, yes.
Q. And has a physician written up a report against you --
A. Oh, yes.
Q. -- critical of your care? And you're familiar -- you're aware thac two physicians can have different methods of approaching the same problem without either one of them being beneath the standard of care?
A. That's true.
Q. And you would agree with me thac just because there was an unfavorable outcome does not mean that there was medical negligence?
MS. ROLLS: in chis case or in general?
BY MR. WILLOUGHBY:
Q. In general.
A. In general, thac's true.
Q. Just so we're clear, the only criticisms you have against Dr. Chak are, one, chat he biopsied a denuded area that he believed may have been the result of some trauma?
A. Correct.
Q. And that he did not get an upright or a KUB after the procedure?
A. That's correct.
Q. Are there any ocher criticisms chat we 'nave not discussed

today?

A. Well, again, if it shows in her deposition thac he called her -- that she called him, and I'm basically reconstructing it from something that Donna and I talked about, that she called him saying she hasn't had a bowel movement and he prescribed an enema, if that is his response, then thac, I feel, is inappropriate.

Patients that have jusc had a colonoscopy, who have been completely cleaned out, should not have a problem with inability to pass bowel, that that should have been the sign that maybe something else was going on and further investigation such as a KUB or even a trip to the ER may have been indicated.

Q. Can the narcotics used during colonoscopy cause a person to become constipated?

A. No.

Q. Cannot?

A. No, because the amounts being used are not significant and *by* chac time frame should be gone and normal bowei function should have returned.

Q. Do you know whether she was deeply sedated?

A. Well, based on the levels that she gave from the sedation record, I don't think she was that terribly sedated. And I believe, if I'm incorrect I'm going to correct myself, that she was reversed. She received 5 -- 75 milligrams of Demerol and two milligrams of Versed that were given during the procedure,

which really isn't a whole heck of a lot.

Q. Does 75 milligrams of Demerol **and** two milligrams of Versed effect all people the same way?

A. No, it doesn't.

Q. Could these medications cause her to be constipated?

A. I *don't* believe so.

Q. So it's not possible?

A. If she was getting 75 milligrams every four hours for two days, I'd say you've got a very good argument, but a one-shot dose like this, no.

Q. If the facts show that Mrs. Fisher took a fleet enema and within an hour or two hours of first calling Dr. Chak, called him back --

A. Okay.

Q. -- and he said immediately get to the hospital --

MS. KOLIS: I'll stipulate for the record that those are the facts. How is that one? Make it nice and easy.

BY MR. WILLOUGHBY:

Q. Would that one-hour delay have changed the scenario or one-to two-hour delay have changed the scenario?

A. No.

Q. Okay. If the facts show that Mrs. Fisher -- Strike that.

Are there any other criticisms thac you have against Dr. Chak chat we have not already discussed?

A. I don't believe so.

MR. WILLOUGHBY: Can I have just a minute?

MS. KOLIS: Sure.

THE WITNESS: Please.

(Brief recess taken.)

MR. WILLOUGHBY: Doctor, I don't have any more questions for you. You're very gracious.

THE WITNESS: Thank you.

- - -

(Signature not waived.)

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(Thereupon, the deposition was concluded at 2:59 o'clock p.m. on Wednesday, October 22, 1997.)

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A F F I D A V I T

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STATE OF _____)
) SS:
COUNTY OF _____,)

Richard E. Schlanger, M.D., Ph.D., having been duly placed under oath, deposes and says that:

I have read the transcript of my deposition taken on Wednesday, October 22, 1997, and made all necessary changes and/or corrections as noted on the attached correction sheet, if any.

_____
Richard E. Schianger, M.D., Ph.D.

Placed under oath before me and subscribed in my presence this _____ day of _____, 19___

_____
Notary Public

My Commission Expires: _____

- - -

C E R T I F I C A T E

- - -

State of Ohio,)
) SS:
County of Franklin,)

- - -

I, Rose Marie Prater, Registered Professional Reporter and Notary Public in and for the State of Ohio, hereby certify that the foregoing **is** a true and accurate transcript of ehe deposition testimony, taken under oath on the date hereinbefore set forth, of Richard E. Schlanger, M.D., Ph.D. .

I further certify that I am neither attorney or counsel for, nor related to or employed by any of the parties to the action in which the deposition was taken, and further that I am not a relative or employee of any attorney or counsel employed in this case, nor am I financially interested in the action.

Rose Marie Prater,
Registered Professional
Reporter and Notary Public
in and for the State of
Ohio.

My Commission Expires:
September 16, 2002.

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