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 IN THE COURT OF COMMON PLEAS OF CUYAHOGA COUNTY, OHIO DIANE COLVIN, ADMINISTRATOR OF THE ESTATE OF GREGORY COLVIN, Plaintiff, vs. Case No. KEITH KRUITHOFF, M.D., ET AL., 388614 DEPOSITION OF STEVEN K. SCHMITT, M.D. Friday, September 29, 2000 DEPOSITION OF STEVEN K. SCHMITT, M.D., reamination under the statute, taken before me, Karen M. Patterson, a Registered Merit Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at the offices of Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, Ohio, at 10:00 o'clock a.m. on the day and date set forth above. 	 STEVEN K. SCHMITT, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows: EXAMINATION OF STEVEN K. SCHMITT, M.D. BY MS. TOSTI: Q. Doctor, would you please state your name for us. A. Steven Schmitt. Q. And what is your home address? A. My home address is 435 Medway, M-E-D-W-A-Y, Road, Highland Heights, Ohio, 44113. Q. Is that a single-family home? A. It is. Q. And was that also true at the time that you rendered care to Gregory Colvin in 1997? A. Yes. Q. In 1998, who was your employer?
Page 2	Page 4
1 APPEARANCES:	1 A. Cleveland Clinic Foundation.
On behalf of the Plaintiff:	2 Q. And that is also your current
Becker & Mishkind Co., L.P.A., by 4 JEANNE TOSTI, ESQ.	3 employer? 4 A. Yes.
Suite 660 Skylight Office Tower 5 1660 West 2nd Street	5 Q. And aside from Cleveland Clinic, do
Cleveland, Ohio 44113	6 you provide professional services for any other
6 (216)241-2600 7 On behalf of the Defendant Cleveland Clinic	7 entity?
Foundation:	8 A. I provide no patient care for any
STEPHEN A. SKIVER, ESQ.	
9 30025 E. River Road	9 other entity.
Perrysburg, Ohio 43551 10 (419) 666-3417	10 Q. Any other type of professional
Perrysburg, Ohio 43551 10 (419) 666-3417 11 On behalf of the Defendant Keith Kruithoff. M.D	10 Q. Any other type of professional
Perrysburg, Ohio 43551 10 (419) 666-3417 11 On behalf of the Defendant Keith Kruithoff. M.D 12 Bonezzi Switzer Murphy & Polito Co	 Q. Any other type of professional services for any other entity besides the Cleveland Clinic? A. Occasional lectures for drug
Perrysburg, Ohio 43551 10 (419) 666-3417 11 On behalf of the Defendant Keith Kruithoff. M.D 12 Bonezzi Switzer Murphy & Polito Co., 13 L.P.A., by JOHN S. POLITO, ESQ.	 Q. Any other type of professional services for any other entity besides the Cleveland Clinic? A. Occasional lectures for drug companies.
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Perrysburg, Ohio 43551 10 (419) 666-3417 11 On behalf of the Defendant Keith Kruithoff. M.D 12 Bonezzi Switzer Murphy & Polito Co., 13 L.P.A., by JOHN S. POLITO, ESQ. 14 Leader Building, Suite 1400 526 Superior Avenue 15 Cleveland, Ohio 441 14-1491 (216) 875-2767	 Q. Any other type of professional services for any other entity besides the Cleveland Clinic? A. Occasional lectures for drug companies.
Perrysburg, Ohio 43551 10 (419) 666-3417 11 On behalf of the Defendant Keith Kruithoff. M.D 12 Bonezzi Switzer Murphy & Polito Co., 13 L.P.A., by JOHN S. POLITO, ESQ. 14 Leader Building, Suite 1400 526 Superior Avenue 15 Cleveland, Ohio 44114-1491 (216) 875-2767 16 On behalf of the Defendant Ohio Permanente	 Q. Any other type of professional services for any other entity besides the Cleveland Clinic? A. Occasional lectures for drug companies. Q. Have you ever had your deposition taken before? A. I have. Q. How manytimes?
Perrysburg, Ohio 43551 10 (419) 666-3417 11 On behalf of the Defendant Keith Kruithoff. M.D 12 Bonezzi Switzer Murphy & Polito Co., 13 L.P.A., by JOHN S. POLITO, ESQ. 14 Leader Building, Suite 1400 526 Superior Avenue 15 Cleveland, Ohio 44114-1491 (216) 875-2767 16 On behalf of the Defendant Ohio Permanente 17 Medical Group:	 Q. Any other type of professional services for any other entity besides the Cleveland Clinic? A. Occasional lectures for drug companies. Q. Have you ever had your deposition taken before? A. I have. Q. How manytimes? A. Once.
Perrysburg, Ohio 43551 10 (419) 666-3417 11 On behalf of the Defendant Keith Kruithoff. M.D 12 Bonezzi Switzer Murphy & Polito Co., 13 L.P.A., by JOHN S. POLITO, ESQ. 14 Leader Building, Suite 1400 526 Superior Avenue 15 Cleveland, Ohio 44114-1491 (216) 875-2767 16 On behalf of the Defendant Ohio Permanente 17 Medical Group:	 Q. Any other type of professional services for any other entity besides the Cleveland Clinic? A. Occasional lectures for drug companies. Q. Have you ever had your deposition taken before? A. I have. Q. How manytimes? A. Once. Q. And why was your deposition being
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Perrysburg, Ohio 43551 10 (419) 666-3417 11 On behalf of the Defendant Keith Kruithoff. M.D 12 Bonezzi Switzer Murphy & Polito Co., 13 L.P.A., by JOHN S. POLITO, ESQ. 14 Leader Building, Suite 1400 526 Superior Avenue 15 Cleveland, Ohio 44114-1491 (216) 875-2767 16 On behalf of the Defendant Ohio Permanente 17 Medical Group: 18 Roetzel & Andress, by INGRID KINKOPF-ZAJAC, ESQ 19 1375 East 9th Street Cleveland, Ohio 44114 20 (216) 623-0150 21	 Q. Any other type of professional services for any other entity besides the Cleveland Clinic? A. Occasional lectures for drug companies. Q. Have you ever had your deposition taken before? A. I have. Q. How manytimes? A. Once. Q. And why was your deposition being taken? And by that I mean in what capacity; were you a fact witness, a Defendant, a medical
Perrysburg, Ohio 43551 10 (419) 666-3417 11 On behalf of the Defendant Keith Kruithoff. M.D 12 Bonezzi Switzer Murphy & Polito Co., 13 L.P.A., by JOHN S. POLITO, ESQ. 14 Leader Building, Suite 1400 526 Superior Avenue 15 Cleveland, Ohio 44114-1491 (216) 875-2767 16 On behalf of the Defendant Ohio Permanente 17 Medical Group: 18 Roetzel & Andress, by INGRID KINKOPF-ZAJAC, ESQ 19 1375 East 9th Street Cleveland, Ohio 44114 20 (216) 623-0150 21 22	 Q. Any other type of professional services for any other entity besides the Cleveland Clinic? A. Occasional lectures for drug companies. Q. Have you ever had your deposition taken before? A. I have. Q. How manytimes? A. Once. Q. And why was your deposition being taken? And by that I mean in what capacity; were you a fact witness, a Defendant, a medical
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1 (Pages **I** to 4)

	Page 5	Page
	-	
1	A. It was.	1 expert in a medical/legal case?
2	Q. When was your deposition taken?	2 A. No.
3	A. Earlier this year. I can't remember	3 Q. Now, doctor, you are currently
4	exactly when.	4 licensed in the State of Ohio; is that correct?
5	Q. Was your care in question in that	5 A. Yes.
6	case?	6 Q. Are you licensed in any other states?
7	A. No.	7 A. No.
8	Q. Do you recall the name of the	8 Q. And at the time that you rendered care
9	Plaintiff in that case?	9 to Gregory Colvin, you were also so licensed ir
10	A. Todaro.	10 Ohio?
11	Q. Is that case still pending?	11 A. Yes.
12	A. Yes.	12 Q. Has your license in Ohio ever been
13	Q. Can you tell me what the allegation of	13 suspended, revoked or called into question?
14	negligence is in that case, please?	14 A. No.
15	MR. SKIVER: Just very briefly,	15 Q. You are board certified in infectious
16	doctor, if you know.	16 disease and in internal medicine; is that
17	A. It was a case of endocarditis that	17 correct?
18	seeded a prostheticjoint and subsequently led to	18 A. Yes.
19	debility on the patient's part.	19 Q. Did you pass both of those
20	Q. Did the patient die?	20 certifications on your first attempt?
21	A. No.	21 A. Yes.
22	Q. I want to go over a few of the ground	22 Q. I take it you have hospital privileges
23	rules for depositions. I'm sure counsel has had	23 here at Cleveland Clinic; correct?
24	a chance to talk with you. This is a	24 A. Yes.
24		
25	question-and-answer session; it's under oath.	25 Q. Do you have hospital privileges at any
1 2 3 4 5 6 7 8 9 10 11 2 13 14 15 16 17 18 19 20 21	It's important that you understand my questions. If you don't understand them, just tell me, and I'll be happy to repeat the question or rephrase them. Otherwise, I'm going to assume that you understood my question and that you're able to answer it. It's important that you give all of your answers verbally. The court reporter can't take down head nods or hand motions. If at some point you would like to refer to the medical records that counsel has provided to you, please feel free to do so. Also, at some point during the deposition, defense counsel may choose <i>to</i> enter an objection. You are still required to answer my question unless counsel instructs you not to do so. Do you understand those instructions? A. Yes. Q. Have you ever been named as a Defendant in a medical negligence case? A. No.	 other area hospitals? A. No. Q. Have your hospital privileges ever been suspended, revoked or called into question? A. No. MS. TOSTI: Would you put an exhibit sticker on this for me, please. (Thereupon, PLAINTIFF'S Deposition Exhibit 1 was mark'd for purposes of identification.) Doctor, I'm handing you what has been marked as Plaintiffs Exhibit 1, and I would ask if you would just identify that document for us. A. This is my curriculum vitae. Q. Is it current and up to date, or are there any corrections that you would like to make to that document? A. There may be some poster presentations from a meeting a week or two ago, but nothing other than that. Q. Now, doctor, you served both a
22 23 24 25	 Q. Have you ever given trial testimony in a medical negligence case? A. No. Q. Have you ever acted as a medical 	 residency and a fellowship here at Cleveland Clinic; correct? A. Yes. Q. And currently you hold the position of

2 (Pages 5 to 8)

Page 9	Page 11
1 staff physician here; correct?	1 A. I have not.
2 A. Correct.	2 Q. And then there was a set of records
3 Q. Do you have any other administrative	3 for a second admission when he came in, I
4 titles here at the Cleveland Clinic besides staff	4 believe, on February 23rd for about four days.5 You looked at some records from that admission?
5 physician? 6 A. No.	6 A. Very briefly.
7 Q. Doctor, you have a number of	7 Q. Have you looked at any Kaiser or
8 publications that are listed on your curriculum	8 Cleveland Clinic outpatient records?
9 vitae. Do any of those publications deal with	9 A. No.
10 the subject matters of endocarditis?	10 Q. Have you at any time reviewed the
11 A. No.	11 actual tapes from any echocardiograms?
12 MR. SKIVER: Wait a minute, doctor.	12 A. No.
13 There might have been one here that I saw.	13 Q. Any deposition testimony have you
14 A. Oh, one, pardon me. Correction. 15 Abstract.	14 reviewed? 15 A. No.
16 Q. Would you tell me what the title of	16 Q. And in preparation for this
17 that abstract is.	17 deposition, have you referred to any textbooks or
18 A. "Of back pain and stroke:	18 journal articles?
19 Staphylococcus aureus endocarditis with multiple	19 A. No.
20 septic emboli."	20 Q. Since this case was filed, have you
21 Q. And is that abstract published in any	21 discussed the case with any physicians other than
22 particular publication?	22 Mr. Skiver? 23 A. When I first heard that there was
23A.No.24Q.And aside from that particular	 A. When I first heard that there was litigation, I began to discuss the case with my
25 abstract, is there anything else on your	partner, David Longworth, for about one minute,
Page 10	Page 12
1 curriculum vitae that deals with endocarditis?	1 and he reminded me that we ought not be, so we
2 A. No.	2 stopped.
3 Q. In May of 1998, did you hold any	3 Q. And in the brief time that you
4 administrative positions at the Cleveland Clinic	4 discussed it with him, what did you discuss?
5 aside from your designation as staff physician? 6 A. No.	5 A. That there was litigation.6 Q. Did you discuss any of the facts in
6 A. No. 7 Q. Have you ever taught or given formal	7 the case?
8 lecture on the subject matter of endocarditis?	8 A. No, not that I recall.
9 A. No.	9 Q. Other than with counsel, have you
IO Q. Tell me what you have reviewed for	10 discussed this case with anyone else?
11 this deposition.	11 A. No.
12 A. I have reviewed in detail the	12 Q. Do you have, aside from what is in the
13 admission from May of 1998; May 12, 1998 to May	13 medical records from Gregory Colvin's May 12th
13 admission from May of 1998; May 12, 1998 to May 14 17th, 1998.	13 medical records from Gregory Colvin's May 12th14 admission, do you have any personal notes or a
 admission from May of 1998; May 12, 1998 to May 17th, 1998. Q. There are a number of other medical 	13 medical records from Gregory Colvin's May 12th14 admission, do you have any personal notes or a15 personal file on this case?
 admission from May of 1998; May 12, 1998 to May 17th, 1998. Q. There are a number of other medical records that pertain to care that this patient 	 medical records from Gregory Colvin's May 12th admission, do you have any personal notes or a personal file on this case? A. No.
 admission from May of 1998; May 12, 1998 to May 17th, 1998. Q. There are a number of other medical 	 medical records from Gregory Colvin's May 12th admission, do you have any personal notes or a personal file on this case? A. No.
 admission from May of 1998; May 12, 1998 to May 17th, 1998. Q. There are a number of other medical records that pertain to care that this patient received at the Cleveland Clinic. Have you only 	 medical records from Gregory Colvin's May 12th admission, do you have any personal notes or a personal file on this case? A. No. Q. Have you ever generated any such
 admission from May of 1998; May 12, 1998 to May 17th, 1998. Q. There are a number of other medical records that pertain to care that this patient received at the Cleveland Clinic. Have you only seen the one admission on Gregory Colvin? A. I have briefly seen an earlier admission from, I believe, February of 1998, but 	 13 medical records from Gregory Colvin's May 12th 14 admission, do you have any personal notes or a 15 personal file on this case? 16 A. No. 17 Q. Have you ever generated any such 18 notes? 19 A. No. 20 Q. Doctor, is there a textbook or a
 admission from May of 1998; May 12, 1998 to May 17th, 1998. Q. There are a number of other medical records that pertain to care that this patient received at the Cleveland Clinic. Have you only seen the one admission on Gregory Colvin? A. I have briefly seen an earlier admission from, I believe, February of 1998, but have not reviewed it in detail for this. 	 medical records from Gregory Colvin's May 12th admission, do you have any personal notes or a personal file on this case? A. No. Q. Have you ever generated any such notes? A. No. Q. Doctor, is there a textbook or a particular book that you consider to be the best
 admission from May of 1998; May 12, 1998 to May 17th, 1998. Q. There are a number of other medical records that pertain to care that this patient received at the Cleveland Clinic. Have you only seen the one admission on Gregory Colvin? A. I have briefly seen an earlier admission from, I believe, February of 1998, but have not reviewed it in detail for this. Q. He had an admission in which he had 	 medical records from Gregory Colvin's May 12th admission, do you have any personal notes or a personal file on this case? A. No. Q. Have you ever generated any such notes? A. No. Q. Doctor, is there a textbook or a particular book that you consider to be the best in your field of infectious disease?
 admission from May of 1998; May 12, 1998 to May 17th, 1998. Q. There are a number of other medical records that pertain to care that this patient received at the Cleveland Clinic. Have you only seen the one admission on Gregory Colvin? A. I have briefly seen an earlier admission from, I believe, February of 1998, but have not reviewed it in detail for this. Q. He had an admission in which he had his mitral valve replaced. Did you look at any 	 medical records from Gregory Colvin's May 12th admission, do you have any personal notes or a personal file on this case? A. No. Q. Have you ever generated any such notes? A. No. Q. Doctor, is there a textbook or a particular book that you consider to be the best in your field of infectious disease? A. There are several excellent textbooks
 admission from May of 1998; May 12, 1998 to May 17th, 1998. Q. There are a number of other medical records that pertain to care that this patient received at the Cleveland Clinic. Have you only seen the one admission on Gregory Colvin? A. I have briefly seen an earlier admission from, I believe, February of 1998, but have not reviewed it in detail for this. Q. He had an admission in which he had his mitral valve replaced. Did you look at any of those records from the actual mitral valve 	 medical records from Gregory Colvin's May 12th admission, do you have any personal notes or a personal file on this case? A. No. Q. Have you ever generated any such notes? A. No. Q. Doctor, is there a textbook or a particular book that you consider to be the best in your field of infectious disease? A. There are several excellent textbooks with good information; some of it I agree with,
 admission from May of 1998; May 12, 1998 to May 17th, 1998. Q. There are a number of other medical records that pertain to care that this patient received at the Cleveland Clinic. Have you only seen the one admission on Gregory Colvin? A. I have briefly seen an earlier admission from, I believe, February of 1998, but have not reviewed it in detail for this. Q. He had an admission in which he had his mitral valve replaced. Did you look at any 	 medical records from Gregory Colvin's May 12th admission, do you have any personal notes or a personal file on this case? A. No. Q. Have you ever generated any such notes? A. No. Q. Doctor, is there a textbook or a particular book that you consider to be the best in your field of infectious disease? A. There are several excellent textbooks

3 (Pages 9 to 12)

	Page 13		Page 15
1 Q. Which ones do you find t	that you use	1 eff	fect a cure?
2 occasionally?		2	A. Not in every circumstance.
3 A. I use Mandell's textbook			Q. So you're aware of some instances
4 Q. Do you find generally the			here it has been treated effectively by medical
5 information is reliable in that boo			eans rather than surgical means?
6 A. Lagree with it sometimes			A. On occasion.
7 sometimes I disagree.			Q. Can you give me a ballpark estimate as
8 Q. As you sit here today, ar			how often that occurs?
 9 particular publications that you b 10 specific relevance to this case? 			A. Not very often.
11 is if there's any that you know of			Q. So would it be fair to say, in most ases of prosthetic valve endocarditis, there's
12 particular point in time.			bing to have to be surgical intervention to cure
13 A. Not specifically.			e infection?
14 Q. Have you participated in			A. In most cases, there is surgical
15 dealing with the subject matter of			tervention.
16 endocarditis?			Q. Doctor, do you know what the mortality
17 A. No.		-	te is for early prosthetic valve endocarditis?
18 Q. And is your practice limit			A. I don't off the top of my head.
19 field of infectious disease?	1		Q. If prosthetic valve endocarditis goes
20 A. Yes.			ntreated, would you agree it's almost
21 Q. How often do you see pa	atients with 2		niversally fatal?
22 prosthetic valve endocarditis?	2	22	A. If untreated?
23 A. Perhaps five in a year.		-	Q. Yes.
24 Q. Do you know what the in			A. Yes.
25 early prosthetic valve endocardit	tis is after 2	25	Q. And would you agree that, given the
	D		
	Page 14		Page 16
1 valve replacement?			e-threatening nature of prosthetic valve
2 A. That varies according to			ndocarditis, physicians caring for patients with
3 Q. What is it at Cleveland C			osthetic heart valves must be extremely
4 A. I'm not certain.			gilant for signs and symptoms of prosthetic
5 Q. Who would have those s 6 A. I'm not sure. Perhaps the			alve endocarditis?
6 A. I'm not sure. Perhaps the 7 of surgery might, but I don't know			A. I would agree that patients should be
8 Q. That's not something that		-	llowed, yes. Q. Doctor, what type of signs or symptoms
9 infectious disease department w			Q. Doctor, what type of signs or symptoms ould raise reasonable suspicion for prosthetic
10 rate of prosthetic valve endocard			alve endocarditis?
11 Cleveland Clinic?		11	MR. SKIVER: Objection.
12 A. Not the department of inf		12	Q. You may answer.
13 disease. Surgeons might.			A. Fever, chills, sweats.
14 Q. Is there a particular orga			
	111511111111111111111111111111111111111	14	Q. Weight loss?
15 the most common organism to ca			
15 the most common organism to ca16 valve endocarditis?	ause prosthetic 1	15	
 15 the most common organism to ca 16 valve endocarditis? 17 A. The most common organ 	ause prosthetic 1	15 16	A. Can be. It's a nonspecific finding.
 15 the most common organism to ca 16 valve endocarditis? 17 A. The most common organ 18 Q. Yes. 	ause prosthetic 1 1 nism 1 1	15 16 17 18	A. Can be. It's a nonspecific finding.Q. Anemia?A. Can be.Q. Elevated erythrocyte sedimentation
 15 the most common organism to ca 16 valve endocarditis? 17 A. The most common organ 18 Q. Yes. 19 Awould be coagulase network 	ause prosthetic 1 ism 1 egative 1	15 16 17 18 19 rat	 A. Can be. It's a nonspecific finding. Q. Anemia? A. Can be. Q. Elevated erythrocyte sedimentation te?
 15 the most common organism to ca 16 valve endocarditis? 17 A. The most common organ 18 Q. Yes. 19 Awould be coagulase ne 20 staphylococci. Also, I think I nee 	ause prosthetic 1 hism 1 egative 1 ed to amend a 20	15 16 17 18 19 rati 20	 A. Can be. It's a nonspecific finding. Q. Anemia? A. Can be. Q. Elevated erythrocyte sedimentation te? A. Yes. But, again, that's a nonspecific
 15 the most common organism to can be called a series of the most common organism. 16 valve endocarditis? 17 A. The most common organism or called a series of the most common organism. 18 Q. Yes. 19 Awould be coagulase new called a series of the most common organism. 19 Awould be coagulase new called a series of the most common organism. 19 Awould be coagulase new called a series of the most common organism. 19 Awould be coagulase new called a series of the most common organism. 19 Awould be coagulase new called a series of the most common organism. 19 Awould be coagulase new called a series of the most common organism. 19 Awould be coagulase new called a series of the most common organism. 19 Awould be coagulase new called a series of the most common organism. 10 Awould be coagulase new called a series of the most common organism. 11 Awould be coagulase new called a series of the most common organism. 12 Awould be coagulase new called a series of the most common organism. 13 Awould be coagulase new called a series of the most common organism. 14 Awould be coagulase new called a series of the most common organism. 15 Awould be coagulase new called a series of the most common organism. 16 Awould be coagulase new called a series of the most common organism. 17 Awould be coagulase new called a series of the most common organism. 18 Awould be coagulase new called a series of the most common organism. 19 Awould be coagulase new called a series of the most common organism. 19 Awould be coagulase new called a series of the most common organism. 19 Awould be coagulase new called a series of the most common organism. 10 Awould be coagulase new called a series of the most common organism. 10 Awould be coa	ause prosthetic 11 hism 1 egative 1 ed to amend a 20 nent of infection 2	15 16 17 18 19 rat 20 21 find	 A. Can be. It's a nonspecific finding. Q. Anemia? A. Can be. Q. Elevated erythrocyte sedimentation tte? A. Yes. But, again, that's a nonspecific nding.
 15 the most common organism to can be called a series of the most common organism. 16 valve endocarditis? 17 A. The most common organism or called a series of the most common organism. 18 Q. Yes. 19 Awould be coagulase new common organism. 19 Awould be coagulase new common organism. 20 staphylococci. Also, I think I new common organism. 21 statement. Probably the department. 22 control also tracks that, just so year control also tracks that. 	ause prosthetic 11 hism 1 egative 1 ed to amend a 20 nent of infection 2 bu have that 22	15 16 17 18 19 rat 20 21 find 22	 A. Can be. It's a nonspecific finding. Q. Anemia? A. Can be. Q. Elevated erythrocyte sedimentation te? A. Yes. But, again, that's a nonspecific nding. Q. Well, doctor, wouldn't fever and
 15 the most common organism to can valve endocarditis? 17 A. The most common organ 18 Q. Yes. 19 Awould be coagulase new staphylococci. Also, I think I new statement. Probably the department control also tracks that, just so year correct answer. 	ause prosthetic 11 hism 1 egative 1 ed to amend a 20 nent of infection 2 pu have that 21	15 16 17 18 19 rat 20 21 find 22 23 chi	 A. Can be. It's a nonspecific finding. Q. Anemia? A. Can be. Q. Elevated erythrocyte sedimentation tte? A. Yes. But, again, that's a nonspecific noting. Q. Well, doctor, wouldn't fever and nills and sweats and fatigue be nonspecific
 15 the most common organism to can be added as the most common organism to can be added as the most common organism. 17 A. The most common organism to can be added as the most common organism. 18 Q. Yes. 19 Awould be coagulase new added as the most common organism. 20 staphylococci. Also, I think I new added as the most common organism. 21 statement. Probably the department of the most common organism. 22 correct answer. 24 Q. Does prosthetic valve based as the most common organism. 	ause prosthetic 11 hism 1 egative 1 ed to amend a 20 nent of infection 2 bu have that 22 acterial 24	15 16 17 18 19 rati 20 21 find 22 23 chi 23 chi 24 als	 A. Can be. It's a nonspecific finding. Q. Anemia? A. Can be. Q. Elevated erythrocyte sedimentation te? A. Yes. But, again, that's a nonspecific nding. Q. Well, doctor, wouldn't fever and nills and sweats and fatigue be nonspecific so?
 15 the most common organism to can valve endocarditis? 17 A. The most common organ 18 Q. Yes. 19 Awould be coagulase new staphylococci. Also, I think I new statement. Probably the department control also tracks that, just so year correct answer. 	ause prosthetic 11 hism 1 egative 1 ed to amend a 20 nent of infection 2 bu have that 22 acterial 24	15 16 17 18 19 rati 20 21 find 22 23 chi 24 als	 A. Can be. It's a nonspecific finding. Q. Anemia? A. Can be. Q. Elevated erythrocyte sedimentation tte? A. Yes. But, again, that's a nonspecific noting. Q. Well, doctor, wouldn't fever and nills and sweats and fatigue be nonspecific

4 (Pages 13 to 16)

5 (Pages 17 to 20)

[I	
	Page 17		Page 19
1	Q. If there's a reasonable suspicion for	1	Q. What would that be an indication of?
2	prosthetic valve endocarditis, what should the	2	A. Inflammation.
3	medical workup entail?	3	Q. And in regard to the complete blood
4	A. Usually it would entail blood	4	count?
5	cultures, many of the blood tests you just	5	A. There can be an elevated white blood
6	mentioned: Complete blood count, sedimentation	6	cell count, there can be anemia, there can be
7	rate, usually blood chemistries, frequently an	7	either elevations or lowerings of platelet count.
8	echocardiogram.	8	Q. Now, in order to diagnose a patient
9	Q. And when you speak of blood cultures,	9	with prosthetic valve endocarditis, do you have
10	what is the procedure for doing the blood	10	to have any particular diagnostic results in
11	cultures? How many blood cultures, how often do	11	order to make that diagnosis?
12	you do them, what spacing of time, those types of	12	A. Usually the finding of multiple
13	things?	13	positive blood cultures or definitive
14	A. It would depend on the situation, but	14	echocardiographic findings.
15	we would ordinarily get several blood cultures in	15	Q. And, doctor, in some instances, do you
16	a space in time of the first few days of	16	make a presumptive diagnosis when you don't have
17	admission.	17	positive blood cultures or definitive echo
18	Q. Well, what would it depend on,	18	findings that the patient has prosthetic valve
19	doctor? You said it would depend on the	19	endocarditis? Is that done in some instances?
20	situation. In some circumstances, you might get	20	A. If there was a strong clinical
21	more than others. For instance, if the blood	21	suspicion on the basis of physical findings, we
22 23	cultures that you initially draw are negative,	22 23	might make that diagnosis.
23	you may get more. Q. Well, doctor, if the patient comes in	23	Q. Now, doctor, how long does it take for blood cultures to come back once they're drawn?
25	and you have a reasonable suspicion for	24	How long does it take before you receive
20	and you have a reasonable suspicion for	25	now long does it take before you receive
11 12 13 14 15	prosthetic valve endocarditis, what type of orders are you going to write for the blood cultures? You have to give some direction as to how many you want and how often, how much time there should be between each culture. Is there any type of procedure that's followed for that? A. What I do is I would order four blood cultures on the first day, and then two 12 hours later. And then I might order a third set the following day around 12 hours after the first. But, again, those times are not absolute. Q. Now, you also mentioned that you draw blood chemistries on the patient. Would there be anything in particular that you would be looking for in the blood chemistries that would assist you in making the diagnosis of endocarditis? A. Sometimes look for kidney dysfunction, which can be a sign of endocarditis. Q. So you would be looking for the portion of the blood chemistry that would reflect the kidney function; correct?	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21	 results? A. It varies widely. It can be a matter of hours to several days. Q. So they will continue to grow the culture. Is there a point when they cut it off and they say it's not going to grow anything anymore? A. Again, that varies per institution, but usually at five to seven days, they will say it's negative. Q. And if it grows something before that, you'll get a report back earlier than the five to seven days; correct? A. Yes. Q. Now, doctor, once initial blood cultures are drawn and there's a reasonable suspicion for prosthetic valve endocarditis, when should antibiotics be started? A. Again, that depends. If there are multiple positive blood cultures, then antibiotics should be started immediately. If
22 23 24	A. Yes.Q. And what would you be looking at? The erythrocyte sedimentation; right?	22 23 24	the patient is unstable, sometimes we'll start antibiotics before we get that full set of blood
24	A. Elevation.	24 25	cultures together, but we try to at least have some blood cultures on the board before we make

	Page 21		Page 23
1	the move to antibiotics, if the patient is	1	A. There are no standards for that.
2	stable.	2	Q. How long would you expect an
3	Q. Would you agree that all the necessary	3	antibiotic to continue to influence the results
4	blood cultures should be obtained and then	4	of a blood culture in a patient?
5	antibiotics should be started?	5	A. That varies quite widely, depending on
6	A. Yes, except when the patient is	6	the level of bacteremia in the patient and the
7	unstable, in which case you start immediately.	7	susceptibility of the organism. So it may not
8	Q. So in those instances, it would be	8	a dose or two of antibiotics may not affect the
9	appropriate to start the antibiotics before	9	blood cultures at all, or may render them sterile
10	there's confirmation of positive blood cultures;	10	for several days.
11 12	correct? A. Yes.	11	Q. Does starting and stopping antibiotics
12	Q. Is it accepted practice to start	12	in a patient with prosthetic valve endocarditis
13	antibiotics and then stop them to take more blood	13 14	have any effect on the virulence of the organism?
15	cultures and then restart the antibiotics?	15	A. With a brief stoppage, it should not.
16	MR. SKIVER: Under what	16	Q. And what do you consider to be a brief
17	circumstances?	17	stoppage?
18	MS. TOSTI: Under any circumstances	18	A. Hours to days, but, really, what
19	with a patient that has prosthetic valve	19	encourages resistance, if that's what you're
20	endocarditis.	20	talking about, would be multiple stops and
21	Is that reasonable?	21	starts.
22	MR. SKIVER: If it's diagnosed he has	22	Q. Doctor, isn't it true that some
23	endocarditis?	23	patients with bacterial endocarditis never have
24	MS. TOSTI: Well, the doctor said that	24	positive blood cultures?
25	definitively you need positive blood cultures	25	A. That's true.
	Page 22		Page 24
	_	1	_
∎ 2	let me rephrase it.	1	Q. Is that also true of some patients
∎ 2 3	_	1 2 3	_
1	let me rephrase it. Q. If there's a presumptive diagnosis of	2	Q. Is that also true of some patients with prosthetic valve bacterial endocarditis?
3	let me rephrase it. Q. If there's a presumptive diagnosis of prosthetic valve endocarditis, is it accepted	2 3	Q. Is that also true of some patientswith prosthetic valve bacterial endocarditis?A. That is true.
3 4 5 6	let me rephrase it. Q. If there's a presumptive diagnosis of prosthetic valve endocarditis, is it accepted practice to start antibiotics, stop them to take additional blood cultures, and then restart the antibiotics?	2 3 4 5 6	 Q. Is that also true of some patients with prosthetic valve bacterial endocarditis? A. That is true. Q. If there's a presumptive diagnosis of bacterial endocarditis and initial blood cultures have been drawn, what would be the typical
3 4 5 6 7	let me rephrase it. Q. If there's a presumptive diagnosis of prosthetic valve endocarditis, is it accepted practice to start antibiotics, stop them to take additional blood cultures, and then restart the antibiotics? A. If the patient is clinically stable	2 3 4 5 6 7	 Q. Is that also true of some patients with prosthetic valve bacterial endocarditis? A. That is true. Q. If there's a presumptive diagnosis of bacterial endocarditis and initial blood cultures have been drawn, what would be the typical antibiotic regimen that would be instituted
3 4 5 6 7 8	let me rephrase it. Q. If there's a presumptive diagnosis of prosthetic valve endocarditis, is it accepted practice to start antibiotics, stop them to take additional blood cultures, and then restart the antibiotics? A. If the patient is clinically stable and there have been a very small number of doses	2 3 4 5 6 7 8	 Q. Is that also true of some patients with prosthetic valve bacterial endocarditis? A. That is true. Q. If there's a presumptive diagnosis of bacterial endocarditis and initial blood cultures have been drawn, what would be the typical antibiotic regimen that would be instituted before blood culture results come back? What
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3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 let me rephrase it. Q. If there's a presumptive diagnosis of prosthetic valve endocarditis, is it accepted practice to start antibiotics, stop them to take additional blood cultures, and then restart the antibiotics? A. If the patient is clinically stable and there have been a very small number of doses of antibiotics given, in an attempt to maximize your ability to recover the organism, which is very important in treating, it is sometimes reasonable to stop the antibiotics briefly, collect more blood cultures, and then restart. Q. If a patient has prosthetic valve endocarditis and receives IV doses of antibiotics an hour or two before the blood cultures are drawn, can that cause the blood culture to be falsely negative? A. It can. Q. Is there a usual period of time after which the antibiotic is unlikely to produce an effect on the blood culture results, a certain amount of time you should wait after an 	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	 Q. Is that also true of some patients with prosthetic valve bacterial endocarditis? A. That is true. Q. If there's a presumptive diagnosis of bacterial endocarditis and initial blood cultures have been drawn, what would be the typical antibiotic regimen that would be instituted before blood culture results come back? What antibiotics would we use? A. It would very much depend on the clinical suspicion for the organism. Typically an indolent course, it could it's almost always a combination of antibiotics. But vancomycin, gentamicin are very typically used. Q. Now, if an infected prosthetic valve is known to be incompetent because of endocarditis, is there a duration of time that the patient should be on antibiotics before they're taken to surgery? A. That is individualized on a per patient basis. It depends on the patient's clinical status. Q. What things would you be looking at to

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6 (Pages 21 to 24)

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	Page 25		Page 27
1	surgery?	1	surgeon.
2	A. It would be again, it would vary	2	Q. Did you make recommendations ever to
3	widely. Often patients go to surgery with	3	the surgeon in regard to this patient should go
4	positive blood cultures; sometimes they go with	4	have that valve done as soon as possible?
5	negative blood cultures. So it's really not a	5	A. We make recommendations from the
6	standard according to whether the blood cultures	6	infectious disease point of view that mainly
7	are positive or negative.	7	indicate that we think this is surgical a
8	Q. But from your perspective as an	8	surgical issue where we think the valve needs to
9	infectious disease physician treating a patient,	9	be replaced, whenever the surgeon thinks it's a
10	is there a period of time you like to have the	10	stable situation to do that.
11	patient on antibiotics before surgery? And I	11	Q. What would be the indicators for you
12	understand the surgical decision is not	12	to make a recommendation like that to a surgeon?
13	necessarily in your hands, but is there a period	13	What do you look for in a patient's condition
14	of time that you feel the patient should be on	14	that would tell you to make a recommendation like
15	antibiotics before they go to surgery? And if	15	that to the surgeon?
16 17	there isn't, that's fine; just tell me that.	16	A. If a patient has multiple embolic
1	A. Again, it varies according to the patient. If I think the patient is unstable when	17 18	phenomenon, if a patient has uncontrolled
18 19	I see the patient, then the surgery should be	18	sepsis and by that I mean low blood pressure and heart failure if a patient has
20	immediate. If I think the patient is stable,	20	uncontrolled bloodstream infection, but that's
20	then we would it's not uncommon at all for us	20	usually something that's made over several days.
22	to give several days of antibiotics before going	22	Q. Now, do you have an independent
23	just to try and minimize the amount of infection	23	recollection of Gregory Colvin? Do you remember
23	residual at the time of the surgery.	24	him?
25	<i>Q</i> . Is the prognosis for prosthetic valve	25	A. I don't remember very much, honestly.
1	Page 26 endocarditis better when the infection is treated longer with antibiotics to the point of negative	1 2	Page 28 Q. Do you remember anything in regard to the care that you provided to Gregory Colvin?
3	blood cultures?	3	A. I remember independently, without the
4	A. Again, I think that varies according	4	chart, I remember his condition after he had a
5	to the patient. I think if you have a stable	5	change in his status on the 16th.
6	patient, it is preferable to have negative blood	6	Q. Doctor, feel free to look at the
7	cultures, although there is not a tremendous	7	chart. I'm going to ask you some questions in
8	amount of data to back that up.	8	regard to your care, and it may be helpful to you
9	Q. Doctor, would you agree that there has	9	to reference back to that.
10	to be a high index of suspicion for bacterial	10	When is the first time that Gregory
11	endocarditis when a prosthetic valve patient	11	Colvin came under your care?
12	presents with persistent fever of unknown origin,	12	A. On the 13th of May 1998.
13	fatigue and night sweats?	13	Q. And how is it that you came to see him
14	A. Those can be signs of endocarditis and	14	on that particular day?
	would require investigation		
15	would require investigation.	15	A. We were asked to consult on his care.
15 16	Q. It would raise a red flag, or should	16	Q. Who requested the consult?
15 16 17	Q. It would raise a red flag, or should raise a red flag, in the mind of a physician	16 17	Q. Who requested the consult? MR. SKIVER: If you don't know,
15 16 17 18	Q. It would raise a red flag, or should raise a red flag, in the mind of a physician treating a patient with a known prosthetic valve;	16 17 18	 Q. Who requested the consult? MR. SKIVER: If you don't know, doctor, that's fine.
15 16 17 18 19	Q. It would raise a red flag, or should raise a red flag, in the mind of a physician treating a patient with a known prosthetic valve; correct?	16 17 18 19	 Q. Who requested the consult? MR. SKIVER: If you don't know, doctor, that's fine. A. I can't find an order written, so I'm
15 16 17 18 19 20	Q. It would raise a red flag, or should raise a red flag, in the mind of a physician treating a patient with a known prosthetic valve; correct?A. It would certainly raise the suspicion	16 17 18 19 20	 Q. Who requested the consult? MR. SKIVER: If you don't know, doctor, that's fine. A. I can't find an order written, so I'm not certain.
15 16 17 18 19 20 21	 Q. It would raise a red flag, or should raise a red flag, in the mind of a physician treating a patient with a known prosthetic valve; correct? A. It would certainly raise the suspicion of an infectious disease doctor. 	16 17 18 19 20 21	 Q. Who requested the consult? MR. SKIVER: If you don't know, doctor, that's fine. A. I can't find an order written, so I'm not certain. Q. At the time of the consultation, do
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8 (Pages 29 to 32)

	Page 29		Page 31
1	consult.	1	of the ways that you confirmed the findings, by
2	A. I don't know.	2	putting an underline in?
3	Q. Now, did you see Gregory Colvin then	3	A. Yes.
4	on the 13th and do your own assessment of the	4	Q. Does that underlining have any other
5	patient?	5	significance?
6	A. I did.	6	A. A teaching mechanism also.
7	Q. And at the time that you saw him, was	7	Q. And what is it that you're trying to
8	there anyone else in attendance with you?	8	convey by underlining certain things in the
9	A. Infectious disease fellow.	9	notes?
10	Q. Did you see Gregory Colvin with the	10	A. That we reviewed it together and that
11	infectious disease fellow on the 13th? A. The infectious disease fellow saw	11 12	I confirmed his findings.
12 13	A. The infectious disease fellow saw Gregory Colvin, and then I came after with the	12	Q. Now, in about the middle of that page of the note, it refers to a 2-24 TEE, I believe.
13	fellow and assessed Mr. Colvin.	13	And it says a questionable small echo density
15	Q. Do you recall what time you saw him on	15	anterior commisure, mitral valve versus suture
16	the 13th? Was it morning or afternoon?	16	material. Do you see that?
17	A. I do not independently recall.	17	A. Yes.
18	Q. Could it have been either morning or	18	Q. What's the significance of that
19	afternoon in this case?	19	finding?
20	A. Likely afternoon.	20	A. Unknown.
21	Q. Based on your schedule?	21	Q. I didn't hear you.
22	A. Based on my schedule, afternoon to	22	A. I don't know what the significance of
23	evening.	23	that finding is.
24	Q. Now, there is a clinical note that I	24	Q. That's something that you underlined
25	believe is written by the infectious disease	25	and you also reviewed with the infectious disease
	Page 30		Page 32
1	Page 30 fellow on the 13th. And it begins ID fellow,	1	Page 32 doctor?
1	_	1 2	-
1	fellow on the 13th. And it begins ID fellow, 51-year-old black male electrician, home Cleveland.	2 3	doctor? A. Yes. Q. Did you consider it significant to
2 3 4	fellow on the 13th. And it begins ID fellow, 51-year-old black male electrician, home Cleveland. Is that a note that you read through	2 3 4	doctor? A. Yes. Q. Did you consider it significant to Gregory Colvin's present condition on his
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Page 33		Page 35
1 there must have been a reason for why it was	1	should have been cultured?
2 included in this particular clinical note. Can	2	A. I wasn't caring for him at that time,
3 you tell me what that reason is?	3	so I can't say.
4 A. Just to note the clinical course.	4	Q. Doctor, as an infectious disease
5 Q. You didn't think it had any particular	5	physician, in a patient with a prosthetic valve
6 significance to the diagnosis of presumptive	6	that has an abscess in his neck draining purulent
7 endocarditis that he was admitted for at this	7	fluid and a fever of unknown origin, wouldn't you
8 admission?	8	agree that that should have been cultured?
9 A. We were uncertain as to its	9	MR. SKIVER: Objection. Asked and
10 significance.	10	answered. Go ahead, doctor.
11 Q. Would you agree that, in Gregory	11	A. Again, I did not see Mr. Colvin at
12 Colvin's case, an abscess in his neck that was	12	that time. If there were a very small
13 emitting several cc's of pus over the course of	13	superficial amount, I would not necessarily
14 at least two days was a risk factor for infection	14	culture. If there was a lot of pus, not
15 of his prosthetic valve?	15	responding to therapy, I might.
16 A. It's a risk factor, but there were	16	Q. I want you to assume that he had
17 several negative blood cultures at that point	17	purulent material on two successive days of about
18 which made it less likely.	18	two cc's. Would that be a sufficient amount to
19 Q. Which blood cultures are you referring 20 to?	19 20	culture in his case with his history? MR. SKIVER: Sufficient amount to
20 10? 21 A. I believe he had some blood cultures	20	culture? Does that mean to require culture or
22 drawn at the time of the stitch abscess.	21	Q. To require culture based on what you
23 Q. During the February admission then, he	23	just told me.
24 had those blood cultures?	24	A. I might have cultured, but I would
25 A. Yes.	25	have to see it. I would have to see him.
20 /		
Page 34		Page 36
1 Q. Do you know whether or not all of	1	Q. Do you have an opinion as to whether
2 those blood cultures were done before antibiotic	2	prosthetic valve endocarditis was ruled out
3 therapy was started, doctor?	3	during his February admission at the Cleveland
4 A. Idon't know.	4	Clinic?
5 Q. Would that make a difference as to	5	MR. SKIVER: Objection. I think he
6 whether that abscess in his neck was significant	6	indicated he hasn't gone through those records in
7 if several of those cultures were drawn after		Indicated ne nash i done infoudn indse records in
	7	
	7 8	detail. I don't know how he can answer that. Go
8 antibiotic therapy was started?	1	detail. I don't know how he can answer that. Go ahead, doctor.
8 antibiotic therapy was started?	8	detail. I don't know how he can answer that. Go ahead, doctor.
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9 (Pages 33 to 36) IN REPORTING. INC.

	Page 37	Page	39
1	Q specifically for prosthetic valve	1 lymph nodes can be enlarged at or near an area o	
2	endocarditis?	2 infection.	,
3	MS. KINKOPF-ZAJAC: Objection.	3 Q. And would that be of greater concern	
4	MR. POLITO: Objection.	4 than if there is no lymph node enlargement in the	
5	MR. SKIVER: Objection. Go ahead,	5 presence of infection? As an infectious disease	
6	doctor, if you know.	6 doctor, if you see a localized infection in one	
7	A. No. I did not see Mr. Colvin at that	7 patient and a localized infection with enlarged	
8	time. It's impossible for me to comment on his	8 lymph nodes in another, is there any increased	
9	care at that point.	9 significance attached to the one that has the	
10	Q. On the second page of the infectious	10 lymph node enlargement?	
11	disease fellow's note, about halfway down under	11 A. Not necessarily.	
12	the section of the physical exam for the head,	12 Q. In Gregory Colvin's case, do you think	
13	ear, eyes, nose and throat, I believe it says	13 that the enlarged lymph node that he had on the	
14 15	that there was a positive right-sided cervical lymph node. Do you see that?	right side had any relationship to the stitchabscess that he had on the right side of his	
16	A. Ido see it.	16 neck?	
17	Q. Now, you did a physical exam on him,	17 MR. SKIVER: At what point in time?	
18	and you have confirmed that finding by	18 We've got a three-month difference here. There's	
19	underlining it with the infectious disease	19 no evidence of a stitch abscess at this point in	
20	fellow; correct?	20 time.	
21	A. Yes.	21 MS. TOSTI: At this point in time,	
22	Q. Did you attach any significance to the	22 he's referenced it in the note, so I'm asking.	
23	fact that he had an enlarged cervical lymph node	23 MR. SKIVER: That's a history. I'm	
24	on the right side?	24 sorry, go ahead.	
25	A. It was noted, but that's of unclear	25 A. I don't know.	
	Page 38	Page	40
1	significance. Lymph nodes can be swollen for a	Page 4 1 Q. Now, after you had an opportunity to	40
1	_	1 Q. Now, after you had an opportunity to 2 see Gregory Colvin on the 13th, you concurred	d
2 3	significance. Lymph nodes can be swollen for a variety of reasons. Q. That was on the same side that he had	1 Q. Now, after you had an opportunity to 2 see Gregory Colvin on the 13th, you concurred 3 with the clinical impressions that Gregory Colvi	d
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10 (Pages37 to 40)

11 (Pages 41 to 44)

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	Page 41		Page 43
1	A. Well, I've underlined 51-year-old	1	intensity, et cetera?
2	black male. It doesn't have any special	2	A. I'm looking at the blue night float
3	significance. I've underlined admitted 10-97	3	senior's note from the 12th, which was one day
4	with CHF. That doesn't necessarily support it.	4	before I saw him, and there was a murmur referred
5	I've underlined the part about the 2-24-98 TEE	5	to. And it's approximately the same intensity.
6	with a small echo density versus suture	6	It's noted to be grade three by the senior, and
7	material. That doesn't necessarily support it.	7	Dr. Gumbo and I thought it was likely grade two.
8	I've underlined right IJ stitch abscess	8	So it was about the same.
9	diagnosed, no cultures, discharged 2-27, T max	9	MR. SKIVER: Doctor, the question is:
10	38.2. That doesn't necessarily support it.	10	Do you know if there is a change. I don't want
11	Three weeks ago, he had cardioversion for a-fib.	11	you to be guessing or anything else. Do you know
12	That doesn't necessarily support it.	12	if there is a change.
13	Four days later, back in a-fib, but	13	A. Oh, no.
14	that doesn't necessarily support it. Underlined	14	Q. In the infectious disease fellow's
15	no cough, no chest pain, no dysuria, no diarrhea,	15	note also, there's a notation that the
16	no joint pains. That doesn't necessarily support	16	erythrocyte sedimentation rate is 61. What is
17	it. I've underlined right-sided cervical lymph	17	the normal reference range for the erythrocyte
18	node. That doesn't necessarily support it. I	18	sedimentation rate?
19	have underlined no splenomegaly, no	19	A. It should be around 20 or less.
20	hepatomegaly. That doesn't necessarily support	20	Q. In Mr. Colvin's case, what was the
21	it. I've Underlined the neurologic exam. That	21	significance of that elevated erythrocyte
22	doesn't necessarily support it. I've underlined	22 23	sedimentation rate?
23	musculoskeletal exam; that doesn't necessarily	23 24	A. Likely represented endocarditis.
24	support it.		Q. Now, the last line of the infectious
25	I think that the rest of it all refers	25	disease fellow's note on May 13th, I believe it
	······································		
	Page 42		Page 44
1	to the endocarditis.	1	says, is there a right IJ clot. It's on the
2	Q. So I want to be clear, doctor. In		
		2	A ISEE IL
3		2 3	A. I see it. Q. What was the basis for that query?
3	regard to the echo density that was seen on the 2-24 echo and the stitch abscess that there was	2 3 4	Q. What was the basis for that query?
1	regard to the echo density that was seen on the 2-24 echo and the stitch abscess that there was	3 4	Q. What was the basis for that query? You have underlined that.
4	regard to the echo density that was seen on the	3	Q. What was the basis for that query?You have underlined that.A. I don't recall specifically.
4 5	regard to the echo density that was seen on the 2-24 echo and the stitch abscess that there was no culture done on and the right-sided cervical	3 4 5	 Q. What was the basis for that query? You have underlined that. A. I don't recall specifically. Q. Do you recall what evidence there was
4 5 6	regard to the echo density that was seen on the 2-24 echo and the stitch abscess that there was no culture done on and the right-sided cervical lymph node that you found on physical exam, those	3 4 5 6	Q. What was the basis for that query?You have underlined that.A. I don't recall specifically.
4 5 6 7	regard to the echo density that was seen on the 2-24 echo and the stitch abscess that there was no culture done on and the right-sided cervical lymph node that you found on physical exam, those three things, did you attach any significance to	3 4 5 6 7	 Q. What was the basis for that query? You have underlined that. A. I don't recall specifically. Q. Do you recall what evidence there was that would raise that as a question, what the
4 5 6 7 8	regard to the echo density that was seen on the 2-24 echo and the stitch abscess that there was no culture done on and the right-sided cervical lymph node that you found on physical exam, those three things, did you attach any significance to them in regard to your diagnosis of prosthetic	3 4 5 6 7 8	 Q. What was the basis for that query? You have underlined that. A. I don't recall specifically. Q. Do you recall what evidence there was that would raise that as a question, what the findings, the clinical findings, were that would
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12 (Pages 45 to 48)

11		[
	Page 45		Page 47
	A. Diagnostic study for a clot would be	1 2	A. It raised concern, but he appeared stable when I saw him.
$\begin{vmatrix} 2 \\ 2 \end{vmatrix}$	an ultrasound. Q. And was an ultrasound done in this	1	Q. But that could change very suddenly in
3		3	
4	case?	4	these types of patients; correct, when you have
5	A. I can't find evidence of one.	5	got rocking and dehiscence of a valve caused by
6	Q. If in fact he had an infected clot,	6	infection?
7	how would that be treated?	7	A. It can, but often patients have that
8	A. Typically with antibiotics.	8	kind of finding, and it goes unchanged for
9	Q. So would it have been the same	9	several days.
10	treatment as it would have been for the	10	Q. Now, doctor, you indicated in your
11	endocarditis?	11	note that you wanted the antibiotics temporarily
12	A. Yes.	12	held; correct?
13	Q. So there wouldn't be anything	13	A. Yes.
14	different even if you knew that was there?	14	Q. Why weren't the necessary cultures
15	A. No.	15	drawn before starting the antibiotics?
16	Q. Now, doctor, did you also write your	16	A. I wasn't caring for Mr. Colvin at that
17	own note on the 13th for this patient?	17	point.
18	A. Yes.	18	Q. I understand that, doctor, but I'm
19	Q. And at the end of the note that you	19	asking you if you know why the necessary blood
20	wrote, would you tell us what your plan of care	20	cultures were not drawn before the antibiotics
21	was for the patient. If you could just read	21	were initiated.
22	through what you have written there.	22	A. I do not know.
23	A. Temporarily hold antibiotics. Collect	23	Q. Would you agree that they should have
24	blood cultures this p.m. and tomorrow a.m.	24	been all drawn before antibiotics were
25	Hopefully first set will be positive. Open heart	25	initiated?
11	Page 46		Page 48
1		1	
1	surgery ASAP. Discuss with Dr. Miller	1	MS. KINKOPF-ZAJAC: Objection.
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Page 49	Page 51
■ with him?	1 MR. SKIVER: Objection. Go ahead,
2 A. I do not specifically remember the	2 doctor.
3 conversation. Ordinarily, it means that I've	3 A. I didn't see Mr. Colviin at that time.
4 discussed it with him.	4 Q. Isn't it likely he had prosthetic
5 Q. Do you remember anything that was	5 valve endocarditis on the 10th
6 transmitted between you and Dr. Miller in regard	6 MS. KINKOPF-ZAJAC: Objection.
7 to what you have noted here?	7 MR. SKIVER: Objection.
8 A. I do not remember.	8 MR. POLITO: Objection.
9 Q. It also notes a reference to Pat	9 Qwhen he went into the emergency
10 Ginley that you said was a surgical assistant in	10 room?
11 cardiothoracic.	11 A. I didn't see Mr. Colvin on the 10th.
12 A. Yes.	12 Q. Do you think he developed it in the
13 Q. Did you have conversation with Pat	 13 three days before you saw him? Is that likely? 14 A. I didn't see Mr. Colvin on the 10th.
14 Ginley? 15 A. I do not recall the conversation, but	15 I think that endocarditis usually exists for
15 A. I do not recall the conversation, but 16 I've noted here that I spoke with him. That's	16 several days before it's diagnosed.
17 all. I do not remember the substance of	17 Q. You think it was appropriate to
18 conversation.	18 discharge him to home from the emergency room on
19 Q. What would be the reason that you	19 the 10th?
20 would be contacting Pat Ginley?	20 MR. POLITO: Objection.
21 A. It would be because I felt that the	21 MS. KINKOPF-ZAJAC: Objection.
22 patient would require surgery at some point.	22 MR. SKIVER: Objection.
23 Q. Would Pat Ginley have any	23 A. I didn't see him. I can't say.
24 responsibilities for scheduling the surgery?	24 Q. Doctor, at the Cleveland Clinic, if
25 A. He would have responsibility for	25 you have a high level of concern that a patient
Page 50	Page 52
1 transmitting information back to the surgeon, and	1 has prosthetic valve endocarditis, could you get
2 then the surgeon would make the decision about	2 a transesophageal echo done on the same day if
3 when the surgery would take place.	3 you felt it was indicated?
4 Q. Was any plan at that time discussed	4 A. We can.
5 regarding when Gregory Colvin would actually go	5 Q. And is it easier to get that done if
6 to surgery?	6 the patient is an inpatient than if it's an
7 MR. SKIVER: Objection. He's already	7 outpatient, a little easier if the patient is
8 indicated he doesn't recall the conversations.	8 hospitalized in the hospital to get a
9 A. I don't remember the conversation. 10 O. Well, when you saw him on the 13th.	 9 transesophageal done than if it's an outpatient? 10 A. I don't know.
10 Q. Well, when you saw him on the 13th, 11 did you have, in your mind, when you thought this	11 Q. Do you have an opinion as to, if a
12 patient should go to surgery?	12 transesophageal or transthoracic echo was done on
13 A. I thought that he should go when it	13 May 10th, whether it would have shown indications
14 was felt by cardiology and cardiothoracic surgery	14 of prosthetic valve endocarditis?
15 that he was stable to go.	15 MR. SKIVER: Objection. Go ahead,
u	-
16 Q. Now, Gregory Colvin was seen at	16 doctor.
17 Cleveland Clinic's ER on the 10th of May, just	17 MS. KINKOPF-ZAJAC: Object.
17 Cleveland Clinic's ER on the 10th of May, just18 three days before his admission when you saw him	MS. KINKOPF-ZAJAC: Object.A. I didn't see him on the 10th. I can't
 17 Cleveland Clinic's ER on the 10th of May, just 18 three days before his admission when you saw him 19 with an elevated temperature, shortness of 	 MS. KINKOPF-ZAJAC: Object. A. I didn't see him on the 10th. I can't say.
 17 Cleveland Clinic's ER on the 10th of May, just 18 three days before his admission when you saw him 19 with an elevated temperature, shortness of 20 breath, night sweats, increased erythrocyte 	 MS. KINKOPF-ZAJAC: Object. A. I didn't see him on the 10th. I can't say. Q. Well, doctor, you saw him on the 13th,
 17 Cleveland Clinic's ER on the 10th of May, just 18 three days before his admission when you saw him 19 with an elevated temperature, shortness of 20 breath, night sweats, increased erythrocyte 21 sedimentation rate to 58, anemia. Would you 	 MS. KINKOPF-ZAJAC: Object. A. I didn't see him on the 10th. I can't say. Q. Well, doctor, you saw him on the 13th, and you also saw his echocardiogram from that
 17 Cleveland Clinic's ER on the 10th of May, just 18 three days before his admission when you saw him 19 with an elevated temperature, shortness of 20 breath, night sweats, increased erythrocyte 21 sedimentation rate to 58, anemia. Would you 22 agree that those were indicators of prosthetic 	 MS. KINKOPF-ZAJAC: Object. A. I didn't see him on the 10th. I can't say. Q. Well, doctor, you saw him on the 13th, and you also saw his echocardiogram from that date. If an echo had been done on the 10th, do
 17 Cleveland Clinic's ER on the 10th of May, just 18 three days before his admission when you saw him 19 with an elevated temperature, shortness of 20 breath, night sweats, increased erythrocyte 21 sedimentation rate to 58, anemia. Would you 22 agree that those were indicators of prosthetic 23 valve endocarditis? 	 MS. KINKOPF-ZAJAC: Object. A. I didn't see him on the 10th. I can't say. Q. Well, doctor, you saw him on the 13th, and you also saw his echocardiogram from that date. If an echo had been done on the 10th, do you think it would have shown any indication of
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 17 Cleveland Clinic's ER on the 10th of May, just 18 three days before his admission when you saw him 19 with an elevated temperature, shortness of 20 breath, night sweats, increased erythrocyte 21 sedimentation rate to 58, anemia. Would you 22 agree that those were indicators of prosthetic 23 valve endocarditis? 	 MS. KINKOPF-ZAJAC: Object. A. I didn't see him on the 10th. I can't say. Q. Well, doctor, you saw him on the 13th, and you also saw his echocardiogram from that date. If an echo had been done on the 10th, do you think it would have shown any indication of

13 (Pages 49 to 52) FPORTING INC

		1	
	Page 53		Page 55
1	MS. KINKOPF-ZAJAC: Objection.	1	A. Yes.
2	MR. SKIVER: Go ahead, doctor.	2	Q. And is that also another fellow's
3	A. I didn't see him on the 10th.	3	note?
4	Q. My question was in relation to what	4	A. It's a resident.
5	you saw on the 13th and the extent of his	5	Q. A resident's note.
6	infection. Is it likely, if an echo was done	6	A. Yes.
7	three days before, there would have been evidence	7	Q. Do you know what resident that is?
8	of infection at that time that would have been	8	A. Dr. Koepke.
9	seen on echo?	9	Q. Is that your underlining in his note?
10	MR. POLITO: Objection.	10	A. Yes.
11	MR. SKIVER: Objection.	11	Q. Now, when you saw him on the 15th, did
12	MS. KINKOPF-ZAJAC: Objection.	12	your assessment of him change from your previous
13	A. It's possible. It's possible.	13	assessments?
14	Q. Now, you also saw Mr. Colvin on the	14	A. I have written that I thought he had
15	14th; is that correct?	15	more signs of heart failure.
16	A. Yes.	16	Q. You wrote that he had worsened heart
17	Q. And you then wrote your own note;	17	failure; correct?
18	correct?	18	A. Yes.
19	A. Yes.	19	Q. Was it your impression that Gregory
20	Q. And there was also an infectious	20	Colvin was moving towards cardiac collapse?
21	disease fellow note written that day that	21	A. I don't recall whether I thought he
22	A. Yes.	22	was moving toward cardiac collapse.
23	Q. Did you review that one?	23	Q. Doctor, at the end of your note on May
24	A. Yes.	24	15th, 1998, you wrote OR as soon as possible, and
25	Q. And also confirm it with them?	25	you have it underlined.
	Page 54		Page 56
1	Page 54 A. Yes.	1	A. Yes.
1		1 2	A. Yes.Q. Why do you have that underlined?
	 A. Yes. Q. And in regard to his condition on the 14th, was there any change in your assessment 		A. Yes.Q. Why do you have that underlined?A. Because I felt that he should go to
2	 A. Yes. Q. And in regard to his condition on the 14th, was there any change in your assessment from what you had seen on the previous day? 	2	A. Yes.Q. Why do you have that underlined?A. Because i felt that he should go to the operating room as soon as he was stable
2 3	 A. Yes. Q. And in regard to his condition on the 14th, was there any change in your assessment from what you had seen on the previous day? MR. SKIVER: Let her finish her 	2 3	 A. Yes. Q. Why do you have that underlined? A. Because I felt that he should go to the operating room as soon as he was stable enough based on the surgeon's assessment.
2 3 4 5 6	 A. Yes. Q. And in regard to his condition on the 14th, was there any change in your assessment from what you had seen on the previous day? MR. SKIVER: Let her finish her question up there. 	2 3 4 5 6	 A. Yes. Q. Why do you have that underlined? A. Because I felt that he should go to the operating room as soon as he was stable enough based on the surgeon's assessment. Q. In your opinion, did Gregory Colvin
2 3 4 5 6 7	 A. Yes. Q. And in regard to his condition on the 14th, was there any change in your assessment from what you had seen on the previous day? MR. SKIVER: Let her finish her question up there. A. No change. 	2 3 4 5 6 7	 A. Yes. Q. Why do you have that underlined? A. Because I felt that he should go to the operating room as soon as he was stable enough based on the surgeon's assessment. Q. In your opinion, did Gregory Colvin need urgent surgery when you saw him on the
2 3 4 5 6 7 8	 A. Yes. Q. And in regard to his condition on the 14th, was there any change in your assessment from what you had seen on the previous day? MR. SKIVER: Let her finish her question up there. A. No change. Q. Was there any change in your plan of 	2 3 4 5 6 7 8	 A. Yes. Q. Why do you have that underlined? A. Because I felt that he should go to the operating room as soon as he was stable enough based on the surgeon's assessment. Q. In your opinion, did Gregory Colvin need urgent surgery when you saw him on the 15th?
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14 (Pages 53 to 56)

	Page 57		Page 59
1	A. No, I don't.	1	unstable or stable?
2	Q. I was going to ask a different	2	MS. TOSTI: Unstable.
3	question.	3	A. I felt that he had worsened heart
4	A. I'msorry.	4	failure.
5	Q. Do you have a recollection, or from	5	Q. Was he hemodynamically unstable?
67	anything you reviewed in the record, speaking with any other physicians about Gregory Colvin's	6 7	A. I had not noted his blood pressure at
8	condition, other than the residents that you	8	the time that I saw him, so I will have to say I don't remember.
9	evaluated the patient with?	9	Q. Do you have any recollection of
10	A. I don't remember.	10	speaking to Gregory Colvin or his family about
11	Q. Was there any reason, to your	11	his condition while he was a patient during this
12	knowledge, that prevented Gregory Colvin from	12	admission?
13	going to surgery for valve replacement on May	13	A. I don't have any recollection of the
14	15th, 1998?	14	conversation.
15 16	A. From an infectious disease point of view, there was nothing holding him back, but,	15 16	Q. You don't recall speaking to his family at any time?
10	again, that's a decision made by the surgeon as	10	A. I recall speaking to his family in
18	to when the patient is taken.	18	hospital quarters after he had a clinical
19	Q. And you're not aware of anything else	19	downturn on the 16th.
20	that would have prevented him from going to	20	Q. We'll get to that in a minute.
21	surgery on Friday; correct? I'mjust asking for	21	There is a clinical note written on
22	what you have knowledge of, doctor. You're not	22	the 16th at, I believe, 0630 hours. Is that your
23	aware of anything that would have prevented him	23	clinical note, or one that you confirmed?
24 25	from going to surgery on Friday, May 15th of 98; correct?	24 25	A. This is my clinical note.Q. And you saw the patient early in the
23	conecti	25	Q. And you saw the patient early in the
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Page 58 MR. SKIVER: You're asking from an infectious disease standpoint? MS. TOSTI: I'm asking him knowledge from any base. MR. SKIVER: Doctor, if you feel you can give any other information, go ahead. Q. Do you have any knowledge of anything that was preventing him from going to surgery on May 15th, 1998? A. From an infectious disease point of view, no. Q. Do you have any knowledge from any other source of any other reason why he couldn't go to surgery on May 15th of 1998? I'm not asking you to review the whole record. I'm asking if you have any knowledge. A. I don't remember having any conversation any conversations I had with any of the other physicians as to why not. Q. Not to your knowledge. A. Not to my knowledge. Q. When you saw Gregory Colvin on May 15th of 98, in your opinion, was he	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	Page 60 morning then on the 16th? A. Yes. Q. What was his condition when you saw him at that time? A. I described him as stable but sick. Q. Was his condition any different from what you had seen the previous day on the 15th of May? A. To the best of my recollection, he was not much different than when I had seen him the day before. Q. Now, at the end of your note, you wrote to OR as soon as possible; correct? A. Right. Q. And you had put something similar to that on the previous day as well as on the 13th. A. Yes. Q. What was the plan in regard to taking this patient to surgery? A. The plan was that, when the surgeon felt he was stable to go to surgery, he would go to surgery. Q. Did you have any conversations with
24	hemodynamically unstable?	24	the surgical staff? You had indicated that you
25	MR. POLITO: Objection. Did you say	25	were going to talk with Pat Ginley. Did you have

15 (Pages 57 to 60)

		<u> </u>	
	Page 61		Page 63
1 any type	of conversations with any of the	1	Q. When you saw him on the 16th, what was
	s as to what the plan was as to when he	2	your prognosis for him in the afternoon when you
	ally going to go to surgery?	3	saw him?
	don't recall.	4	A. I have not noted my prognosis. I
5 Q. S	So you don't recall whether even on	5	don't remember.
6 the 16th	there was an actual time or date that he	6	Q. You mentioned that you thought that
	g to go to surgery; correct?	7	you had a conversation with the family sometime
-	don't recall.	8	after you saw him on the 16th. Do you recall who
	Now, doctor, there's another clinical	9	it is that you spoke to?
	ten on the 16th at about 2:40 p.m. Is	10	A. No, I do not.
	your note?	11	Q. Do you recall the content of that
12 A. Y		12	conversation with the family?
	How did you come to write that note?	13	A. I recall some of it. I recall
11	was notified that the patient had nical downturn.	14	discussing that he was very, very ill, and that
	Who notified you?	15 16	he would have a very difficult battle. I don't remember much more than that.
11	believe that it was an infectious	17	Q. Do you recall any plans to take him to
	fellow, but I'm not certain.	18	surgery on the 16th?
	What were you told in regard to what	19	A. I don't recall.
	Irred with Gregory Colvin?	20	Q. Do you have an opinion as to whether
21 A. T	hat he had had apparently abrupt	21	Gregory Colvin should have been taken to open
	abdominal pain and then had hemodynamic	22	heart surgery prior to the time of his death?
	s and had had extracorporeal membrane	23	A. I think that retrospectively, itwe
	tion placed.	24	obviously think it would have been better if he
25 Q. A	And did you do an assessment of him	25	had gone. But there's certainly no guarantee
		1	
	Page 62		Page 64
1 when yo	Page 62 u went to see him?	1	Page 64 that he would have done well with that surgery.
2 A. I	u went to see him?	1	-
2 A. I 3 Q. V	u went to see him? did. What were your findings?		that he would have done well with that surgery. Q. Are you aware of any attempts to schedule Gregory Colvin for surgery prior to the
2 A. I 3 Q. V 4 A. I	u went to see him? did. What were your findings? don't have them noted. I don't have	2 3 4	that he would have done well with that surgery. Q. Are you aware of any attempts to schedule Gregory Colvin for surgery prior to the time that he died?
2 A. I 3 Q. V 4 A. I 5 them no	u went to see him? did. What were your findings? don't have them noted. I don't have ted, so I do not recall.	2 3 4 5	that he would have done well with that surgery.Q. Are you aware of any attempts to schedule Gregory Colvin for surgery prior to the time that he died?A. I don't do surgical scheduling. It's
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September 29,2000

STEVEN K. SCHMITT, M.D. Colvin vs. Kruithoff, M.D., et al.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 9 20 21 22 23 24 25	 A. I don't know. Q. Do you have an opinion as to what point in time his condition was irreversible? A. My feelings were that he was irreversible on the 17th. Q. If Gregory Colvin had gone to surgery for a valve replacement before he suffered the cardiac collapse, do you have an opinion as to whether he would have likely survived the surgery? A. I don't know. Q. Do you have an opinion as to whether earlier treatment with antibiotics and valve replacement would have increased his chances for survival? MR. POLITO: Objection. A. I don't know. Q. Do you have any criticisms of any of the care that Gregory Colvin received after his valve surgery? A. I don't. Q. And do you have any criticism of Gregory Colvin or blame him in any way for the complications that he suffered? A. No. 	Page 67 1 AFFIDAVIT 2 I have read the foregoing transcript from 3 page 1 through 66 and note the following 4 corrections: 5 PAGE 5 PAGE 6 7 7 8 9 10 11 12 13 14 15 16 16 17 17 STEVEN K. SCHMITT, M.D. 19 Subscribed and sworn to before me this 21
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25	Page 66 MS. TOSTI: Doctor, I don't have any further questions for you. MR. SKIVER: Anybody else? He'll review it. MS. TOSTI: Thank you for your time. (Deposition concluded at 11:55 o'clock p.m.)	Page 68 CERTIFICATE State of Ohio,) SS: County of Cuyahoga.) I, Karen M. Patterson, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named STEVEN K. SCHMITT, M.D. was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony. I do further certify that this deposition Was taken at the time and place specified and was completed without adjournment, that I am not a correct transcription of the event of this action INWITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 8th day of October 2000. Karen/M. Patterson, Notary Public Within and for the State of Ohio My commission expires October 7, 2004

17 (Pages 65 to 68)

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	Page 69	
1 2	I N D E X	
3	EXAMINATION OF STEVEN K. SCHMITT, M.D.	
4	BY MS. TOSTI:	
5 6	PLAINTIFE'S Deposition	
7	PLAINTIFF'S Deposition Exhibit 1 was mark'd 8 8	
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