IN THE COURT OF COMMON PLEAS

OF SUMMIT COUNTY, OHIO

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VICKIE MIGLORE, et al.,

Plaintiffs,

vs. Case No.

DAVID COLA, D.O., et al., 99 CV 030973

Defendants.

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DEPOSITION OF KARL D. SCHWARZE, M.D.

Tuesday, October 10, 2000

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Deposition of KARL D. SCHWARZE, M.D., a witness herein, called by the Plaintiffs for examination 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 Karl D. Schwarze, M.D., 224 West Exchange Street, Akron, Ohio, on the day and date set forth above, at 11:40 o'clock a.m.

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APPEARANCES:

On behalf of the Plaintiffs:

Becker & Mishkind Co., L.P.A., by
HOWARD D. MISHKIND, ESQ.
1660 West 2nd Street
Suite 660 Skylight Office Tower
Cleveland, Ohio 44113
(216) 241-2600

On behalf of the Defendant David Cola, D.O.:

Buckingham, Doolittle & Burroughs, by
MARK D. FRASURE, ESQ.
4518 Fulton Drive NW
P.O. Box 35548
Canton, Ohio 44735
800-686-2825

KARL D. SCHWARZE, 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 KARL D. SCHWARZE, M.D.

BY MR. MISHKIND:

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

A. Karl Schwarze.

Q. You are a physician; is that correct?

A. Yes.

Q. We are here, or at least I am here, to take your discovery deposition, as you have been identified as an expert that will be testifying on behalf of Dr. Cola next week when we go to trial. Do you understand that?

A. Next week?

Q. Yes.

MR. FRASURE: Well, when we get to him it might not be next week.

Q. You're aware of the fact the case is set for trial beginning Monday of this coming week, are you not?

A. Yes.

Q. I've had a chance to review the contents of your file, and is everything that you have reviewed in front of you there, doctor?
A. Yes.
Q. And based upon your review, you wrote a report to Mr. Frasure dated October 2, 2000; is that correct?
A. Yes. Whatever the date was on the --
Q. Why don't you get the report in front of you so you don't have to assume that I'm stating anything accurate.
A. Okay. Yes.
Q. And that is the only letter that you have written --
A. Yes.
Q. -- in this case; true?
A. Yes.
Q. In reviewing the material, it appears that you were first contacted by Mr. Frasure to review records sometime towards the end of September of this year; true?
A. Yes.
Q. Would you in fact refer to the letter that is in the material from Mr. Frasure, and, for the record, indicate what the date was that

you were first consulted by Mr. Frasure as it relates to this case, please.

What is the date of that letter, please?

A. 21st of September.

Q. If I could just see that for one moment, please.

A. Sure.

Q. Thank you. And the letter refers to a phone conversation. I presume that phone conversation took place on that date of September 21 or close to that?

A. I think it was prior to that, I believe, yes.

Q. Within a day or two of September 21?

A. Yes.

Q. But the first time that you reviewed any material is after you received this letter of September 21, 2000; true?

A. I believe that was accompanying a packet that was given to me.

Q. So before September 21, 2000, the only information you had was a brief conversation, perhaps the 21st or perhaps the day or two before, with Mr. Frasure; true?

A. Recent conversation. I don't remember the date, but yes.
Q. It certainly wasn't anything beyond the latter part of September, was it?
A. Correct.
Q. And then after you received this letter dated September 21, 2000, you reviewed material which is in front of you; true?
A. Correct.
Q. And in the material, I see that you have reviewed the Cleveland Clinic records; true?
A. Correct.
Q. And information from Dr. Gary Hoffman?
A. Correct.
Q. Is Dr. Hoffman considered an expert in the area of Wegener's granulomatosis?
A. Yes.
Q. Do you consider Dr. Hoffman to be a well respected rheumatologist at the Cleveland Clinic?
MR. FRASURE: Objection. Go ahead.
A. I consider him a rheumatologist at the Cleveland Clinic.

Q. Do you have an opinion as to his reputation or standing as it relates to the investigation of patients with Wegener's granulomatosis?

A. I have no concerns with Dr. Hoffman.

Q. I'm not suggesting that you do. I'm asking you just the opposite. Do you hold him in high reputation, in high regard, as it relates to someone that has a lot of experience both from the standpoint of writings as well as from his clinical experience with Wegener's granulomatosis?

MR. FRASURE: Objection. Go ahead.

A. In my experience, my encounters with Dr. Hoffman have been very favorable.

Q. So my statement is accurate? Well respected?

A. I respect him, yes.

Q. Thank you. In addition to Dr. Hoffman's records from the Cleveland Clinic, you have also seen a letter that he wrote based upon his clinical evaluation to a number of doctors, including Dr. Flauto and Dr. Zarconi; true? He cc'd those doctors on that letter?

A. I saw a letter from Dr. Hoffman, yes.

A. Recent conversation. I don't remember the date, but yes.
Q. It certainly wasn't anything beyond the latter part of September, was it?
A. Correct.
Q. And then after you received this letter dated September 21, 2000, you reviewed material which is in front of you; true?
A. Correct.
Q. And in the material, I see that you have reviewed the Cleveland Clinic records; true?
A. Correct.
Q. And information from Dr. Harry Hoffman?
A. Correct.
Q. Is Dr. Hoffman considered an expert in the area of Wegener's granulomatosis?
A. Yes.
Q. Do you consider Dr. Hoffman to be a well respected rheumatologist at the Cleveland Clinic?
MR. FRASURE: Objection. Go ahead.
A. I consider him a rheumatologist at the Cleveland Clinic.

Q. Do you have an opinion as to his representation or standing as it relates to the investigation of patients with Wegener's granulomatosis?

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Q. Thank you. In addition to Dr. Hoffman's records from the Cleveland Clinic, you have also seen a letter that he wrote based upon his clinical evaluation to a number of doctors, including Dr. Flauto and Dr. Zarconi; true? He cc'd those doctors on that letter?

A. I saw a letter from Dr. Hoffman, yes.

Q. Do you have any reason to take issue with his clinical findings or his statements in his letter?

MR. FRASURE: Wait a minute. That's pretty broad. We don't know what Dr. Hoffman had in front of him when he made those statements. Look at his letter, doc, if you want to.

MR. MISHKIND: It's a discovery deposition. Your objection is noted.

Q. You reviewed Dr. Hoffman's letter; true?

A. Yes.

Q. You reviewed his records; true?

A. I reviewed his letter, yes.

Q. You have reviewed it very recently because you have only been involved in this case for a little bit over a week to ten days; true?

A. Correct.

MR. FRASURE: A week to ten days, Howard? September 21 to October 10th? Let's be fair.

MR. MISHKIND: Two weeks.

MR. FRASURE: Whatever it is.

MR. MISHKIND: Yes.

MR. FRASURE: Look at his letter,

doctor.

MR. MISHKIND: Mark, let me finish my question.

MR. FRASURE: When I take a deposition of your expert, you say doctor, here, you need this record to look.

MR. MISHKIND: I'm not objecting.

MR. FRASURE: If he wants to look at the record, he can. You want him to say he has seen it.

MR. MISHKIND: You want him to look at the records.

MR. FRASURE: He's entitled to look at anything he wants to.

MR. MISHKIND: It's obvious. Let me finish my question and then we'll go from there.

MR. FRASURE: Be fair. That's all I ask.

MR. MISHKIND: Mark, you're going to find that I am extremely fair.

MR. FRASURE: You are. You are very fair.

MR. MISHKIND: Let's do two things. Let's not talk at the same time, and let me finish a question. If you want to object to it,

go ahead and object to it. Then we'll move on.

Q. You have reviewed Dr. Hoffman's material from the Cleveland Clinic; true?

A. True.

Q. You have reviewed his letter that was written to his doctors; true?

A. To a doctor, yes, true.

Q. Do you know which doctor that was?

A. I'd have to look.

Q. Do you want to get the letter in front of you just to confirm who it was that it was written to?

A. Okay. There's a lot of stuff here, so bear with me. Okay.

Q. Have you read that?

A. Yes, I have, sir.

Q. When did you read it last?

A. Within the week.

Q. Go ahead.

A. I don't recall exactly the day I read it.

Q. Within the last ten days; is that a fair statement?

A. Correct.

Q. And when you read the letter -- and if

you need to read it again, you can do so. I'm not trying to cut you off in any respect, notwithstanding what may have been suggested otherwise.

What I asked you is: As you look at what he has stated in his letter and you look at the notes from the Cleveland Clinic that constituted his clinical exam, is there anything that you see that you take issue with or disagree with as it relates to Dr. Hoffman's findings?

A. Let me review it again.

Q. Go right ahead.

A. Okay.

Q. You have now had a chance to rereview it?

A. Yes.

Q. And I think my original question was whether or not there's anything in his report that you take issue with or find to be inaccurate.

A. I take issue with.

Q. In what respect?

A. The assumption that he makes that the diagnosis of Wegener's -- the features leading to the diagnosis started in September of 1997.

Q. And you recognize that Dr. Hoffman saw her in the context of consultation for her treatment, not as it relates to any medical/legal matters; true?

A. Yes. I assume that was correct.

Q. Any other findings or conclusions that you take issue with in Dr. Hoffman's report?

A. This is the second time that I've gone over this, and I still have a problem with one statement. I think it is not highly likely that Vickie will be able to become dialysis-independent.

Q. Okay.

A. I really don't know. It seems like a double negative to me. I don't know, really, what he's saying there; I hope that she will be a good candidate for transplantation in the future.

Q. When Dr. Hoffman saw her, based upon your review of the information, was she or was she not on dialysis?

A. I don't believe she was on dialysis.

Q. When does his record indicate that she saw him?

A. The letter is July 2nd. I don't

recall when she came off dialysis.

Q. All right. Your initial statement was you don't believe that when she saw him at the time that she was seen at the Cleveland Clinic that she was receiving dialysis; true?

MR. FRASURE: He just said he didn't know.

Q. I said your original statement was that you did not believe she was on dialysis when she saw him.

A. I don't believe I said that.

Q. Okay.

A. I don't recall whether she was on dialysis or not.

Q. And, again, you have --

A. I've reviewed the records, but I've done more than one thing since two weeks ago.

Q. Okay. Anything else that you take issue with or have a problem with in his findings?

A. On looking at this again, she remains on dialysis in this letter. So I assume when he saw her, obviously, she was on dialysis. I really don't take issue with the -- when he's writing this letter, the only assumption -- one

of the assumptions is that he assumes that the disease started in September, and I don't disagree with him as to the rest of the letter, but that's a huge assumption on his part. That's all I'm saying.

Q. Do you know what information he had available to him at the time that he obtained the history and made those statements as to when the disease --

A. No, sir, I don't.

Q. Now, you have reviewed Dr. Cola's deposition; correct?

A. Yes, sir.

Q. And you have also read over my client's deposition?

A. Yes.

Q. Did you make any notes at all when you read the depositions?

A. Some pages that I thought were kind of interesting, but that was about it.

Q. Did you write things on those pages, or did you just dog ear them?

A. I circled some of them. I didn't make any significant notes. I circled and then I wrote on a card the pages, but that's about it.

Q. Where are those card pages?
A. It's a three-by-five. I don't think I have it here. I was reading these at home. I don't think I have it here. Do you want me to look in my office? It was one card, three-by-five, on Mrs. Miglore's deposition, just pages that I thought I might want to review again, but that was it. But I circled that -- circled the page number in her deposition, too.
Q. You don't have that card with you today?
A. I don't believe I do, sir.
Q. Is there anything else that you have reviewed or created in the course of your review that you don't have with you today other than this card?
A. No. I mean -- no. Notes for, you know -- I mean, I don't understand what you want me to answer here. What are you specifically asking? Do I have a hard copy of notes of an extended research that I've done on this case? No, I do not. Is that what you're asking?
Q. A moment ago I asked you, when you read her deposition, whether you made any notes, and you said that you circled some pages and then

you made some notes on a card, three-by-five card perhaps.

A. Correct. I wrote the page numbers.

MR. FRASURE: Wrote what?

THE WITNESS: The page numbers.

Q. You said you don't have the three-by-five card with you and that then segued into me asking you if there was anything else that you have either reviewed or prepared, even if it's just a card marking something down that you don't have here today.

A. No, sir.

Q. Okay.

A. The only card was that card.

Q. As far as any medical literature, did you review anything in the medical literature as it relates to the subject matter of Wegener's granulomatosis or glomerulonephritis in connection with this case?

A. Not outside of my normal renal practice. I mean, I have Wegener's cases.

Q. But specifically with regard to the opinions that you hold or your review in this case.

A. No.

Q. Number one, did you review any medical literature?

A. I review medical texts to date.

Q. Did you review any medical texts or medical literature in connection with the preparation of the opinion report that you wrote to Mr. Frasure which is dated October 2nd?

A. No, sir.

Q. Have you ever written anything on the topic of Wegener's granulomatosis?

A. No, sir.

Q. Have you ever lectured on the topic of Wegener's granulomatosis?

A. No, sir.

Q. Have you ever lectured on any topics dealing with vasculitis-related abnormalities?

A. Have I ever lectured?

Q. Yes.

A. Yes.

Q. Would any of those lectures have anything to do with the diagnosis or treatment of Wegener's granulomatosis or any multi-system vasculitis?

A. Yes.

Q. Which lectures or which topics would

those be?

A. During my fellowship and my -- when I was at Baylor College of Medicine, just -- at Baylor University.

Q. On Wegener's or on some other vasculitis?

A. Rapidly progressive glomerulonephritis.

Q. Was this a printed material that you lectured from?

A. No. I had to give a talk on rapidly progressive, and in terms -- it was not a published lecture, if that's what you're asking. Yes, I made notes during that time for making the talk, yes.

Q. Did you put together material that was disseminated to the group that you were speaking to?

A. Correct.

Q. Did you keep a copy of that material?

A. No.

Q. Other than that occasion at Baylor, have you lectured on either the topic of vasculitis, Wegener's granulomatosis, rapidly progressive glomerulonephritis?

A. No, sir. No, sir. You said glomerulonephritis?

Q. Yes.

A. Yes.

Q. Just so that you and I don't cut each other off, I'm going to wait until you're done answering. Do me the favor also, so that you understand what the question is, wait until I finish before you even start venturing an answer. Fair enough?

A. Okay. Sorry.

Q. I had asked about Wegener's. I've asked about vasculitis, and then I also asked about glomerulonephritis. And besides the Baylor lecture, have you either lectured on or written on the topic of glomerulonephritis?

A. Yes.

Q. When and where?

A. Here in Akron at Akron General Hospital, and it may have been also at City, resident lecture on glomerulonephritis.

Q. There are a number of causes of glomerulonephritis; right?

A. Correct.

Q. Wegener's being one of them; true?

A. Correct.
Q. With regard to any of the lectures that you have given on glomerulonephritis, have you disseminated anything in writing to the audience that you were speaking to?
A. Yes.
Q. Do you have any of the written materials that you disseminated?
A. I hope I do.
Q. Was it just something within the last year or so?
A. Within the last year or two.
Q. Is that something that you could retrieve from your office while we're here?
A. If I can, you're welcome.
Q. I'm sorry.
A. Yes. If I can, it would be here.
Q. What I would like to do is complete my questioning, and then before we adjourn, if you can see if you can locate it just to determine whether or not I have any questions for you based upon that. Okay?
A. Okay. It's -- okay.
Q. Did you want to say something? Go ahead.

A. That's all right.
Q. You were going to say something about the material?
A. It's pretty basic.
Q. Are there any articles or authorities in the area that you practice in that you deem to be authoritative as it relates to the diagnosis and treatment of glomerulonephritis?
A. Rephrase that.
Q. Do you consider any medical texts in the area of nephrology or neurology to be authoritative?
A. I guess I have trouble with the term "authoritative." I don't rely on any one source. I hold certain books in high regard. But I don't base a diagnosis based on one text.
Q. Let's talk about the ones that you hold in high regard. Do you consider those to be reasonably reliable sources of information?
A. Reliable.
MR. FRASURE: Objection. Go ahead.
A. Reliable. I do.
Q. And which texts would be at the top of the list that you would deem to be generally reliable sources of information in your field?

MR. FRASURE: Renal disease throughout or just this subject?

MR. MISHKIND: Renal disease.

A. Schrier's books on the kidney. Brenner's book on the kidney. And the computer -- the computer text up-to-date by Burton Rose.

Q. Are there any journal articles or chapters in any of the medical texts that you are familiar with that you deem to be generally reliable sources as it relates to the diagnosis and treatment of Wegener's granulomatosis?

MR. FRASURE: Objection. Go ahead.

A. Reliable. I mean -- that I would review to make sure that I'm up to date?

Q. Yes.

A. The ones stated.

Q. I'm sorry.

A. In the books stated.

Q. So Brenner's would be one of the sources?

A. Brenner's. Up-to-date Schrier's book and Brenner's; probably in that order.

Q. In connection with the opinions that you have expressed in this case, however, is it

fair to say that you have not specifically reviewed that information in those texts?

A. I have read the -- that information, yes.

Q. Prior to preparing your report in this case?

A. Yes.

Q. In both of the textbooks?

A. Yes.

Q. As it relates to Wegener's granulomatosis?

A. Yes.

Q. What else did you review in the medical literature prior to preparing your report?

A. When you say prior to preparing my report --

MR. FRASURE: That goes back 20 years.

A. I'm saying -- when you say prior, it's open-ended. Since I began my fellowship?

Q. Well, you have been involved in this case for roughly two weeks or thereabouts, since September 21 or so, whatever that works out to be. During the preparation of your opinions and

the review of the material, did you review any medical literature in formulating the opinions you hold in this case?

A. Not to formulate the opinion, but, yes, I did read the material, but not to formulate the opinion.

Q. And which material, in the context that I've just said during this two to three-week, two-week period, what material did you review in the medical literature?

A. In the textbooks that I told you.

Q. And do you find the material that you reviewed to be generally consistent with the opinions that you hold in this case?

A. Hard one to answer. I think the information that was in the material I read helped me formulate my opinions on the diagnosis and treatment of Wegener's.

Q. Let's move to a different topic for a moment. Before I do that, though, is there any other literature that you have reviewed for this case?

A. No.

Q. Have you participated as an expert witness in reviewing medical/legal matters prior

to being contacted by Mr. Frasure?
A. Sure.
Q. How long have you been practicing medicine?
A. Including residency?
Q. Since finishing your residency.
A. Since finishing fellowship or just residency?
Q. Fellowship.
A. 1988, 1989, right around there.
Q. When did you first start reviewing medical/legal matters?
A. I can't remember.
Q. Can you give me an estimate?
A. Yes. I'm blanking here, but I think within five years. That's a ballpark figure.
Q. Tell me currently how many cases a year you review.
A. I can't say that I have three cases this year. But prior to that, maybe one or two previous to that.
Q. Do you provide your name or your ability or your willingness to participate as an expert through any of the medical/legal service companies?

A. No, sir.
Q. Have you ever done that?
A. No, sir.
Q. Have you ever advertised?
A. No, sir. I've always been contacted through I don't know how, but that's how --
Q. How many cases have you reviewed in the past for the Buckingham, Doolittle law firm?
A. Including this?
Q. Whatever, if you want to include this or exclude it.
A. One, excluding this.
Q. So two in total?
A. Two in total.
Q. And was that other case at the request of Mr. Frasure?
A. No, sir.
Q. Who was it at the request of?
A. Mr. Banas.
Q. Did you testify in that case?
A. No, sir.
Q. Has your deposition been taken in that case?
A. No, sir.
Q. I take it you reviewed that case

longer ago than you reviewed this case?
A. Yes.
Q. Are you still, to your knowledge, involved as an expert?
A. On that particular case?
Q. On that particular case.
A. I doubt it.
Q. It's been more than a year or so?
A. Yes. After I reviewed the case, I don't think he wanted -- he didn't want -- he didn't want to use me. He didn't like what I had to say. That was my impression.
Q. So you never wrote a report for him?
A. No.
Q. Do you know how it is that Mr. Frasure made contact with you?
A. On the phone.
Q. Did he tell you how it was that he obtained your name?
MR. FRASURE: Well, we met before.
MR. MISHKIND: Please don't testify, Mark. He'll tell me that. Go ahead.
MR. FRASURE: I'm trying to help you.
MR. MISHKIND: I really don't need your help. Thank you.

A. I have been involved in lawsuits, and I became familiar with Mr. Frasure based on that.

Q. When you say you have been involved in lawsuits, have you been named as a Defendant previously?

A. Correct.

Q. Did Mr. Frasure represent you?

A. He was -- can I ask a question here? I saw Mr. Frasure during one of the depositions -- or -- yes, one of the times we met about the case, but Mr. Banas was the one that actually, I think, ran the case.

Q. You had been named as a Defendant and the Buckingham, Doolittle office defended you; true?

A. Correct.

Q. You believe Mr. Banas was the assigned attorney, but Mr. Frasure may have been at one of the depositions in the case?

A. Right. Right.

Q. Have you been named as a Defendant on any other occasions other than the case where you met Mr. Banas and Mr. Frasure?

MR. FRASURE: Objection. Irrelevant. Go ahead, if you remember.

A. Yes.
Q. How many times?
MR. FRASURE: Objection.
A. That's a public record. I don't know exactly. I think -- when you ask that question, do you mean the ones that were just dismissed, too?
Q. I'm asking you where you were served with papers from a courthouse naming you as a Defendant, regardless of what the outcome was, whether it was dismissed, whether you won or lost the case. I'm just asking all comers in terms of cases filed against you.
MR. FRASURE: Objection. Go ahead.
A. I think four. I think four.
Q. And, to your knowledge, are any of those cases still open?
A. No, sir.
Q. Were all the cases up here in Summit County?
A. No, sir.
Q. Where were they?
A. Summit County and Houston, Texas.
Q. When you were at Baylor?
A. Yes, sir.

Q. Of the four cases, how many, to the best of your recollection, are Summit County cases?

A. I said four. Three. Three that I recall. I mean, the number are the ones I recall.

Q. Did any of those cases have anything to do with the diagnosis or treatment of glomerulonephritis?

A. Hard to answer that. Indirectly, yes.

Q. Tell me, when you say "indirectly," yes, what it is that makes it hard to answer that question.

A. One patient, I was the staff nephrologist in Houston at Baylor and the patient had a transplant, and he had a transplant rejection that -- he had acute renal failure posttransplant and we didn't know what the diagnosis was, we didn't know whether it was acute tubular necrosis versus transplant rejection. When we biopsied the patient, he had a severe vasculitic rejection. So if you want to include that as a glomerular disease, that's why I said it the way I did.

Q. There was some type of a nephritis

that was encountered?
A. Oh, yes.
Q. But it was posttransplant or -- was the nephritis posttransplant?
A. Yes.
Q. It was a rejection?
A. It was transplant rejection is what it was.
Q. Did that case go to trial?
MR. FRASURE: Objection.
A. I guess no.
Q. Your deposition was taken in that case, though; correct?
A. Oh, yes. We went down to trial. I came down -- when they took my deposition, and the case was reviewed by many people, okay, it was apparent that I was not at fault. So they dropped me, the Plaintiff's attorney, dropped me and the defense -- it turned out there were more than one person. I was sued, Baylor was also sued, and Baylor agreed to drop me if they could use me as an expert witness. That's what I understand from the case.
So when it went to trial, I was an expert for that case, so when I -- so I no longer

was a Defendant. But when I went to the trial, as soon as they flew us down, the Plaintiff asked if all the witnesses or all the experts were in place, because some of us had wound up in Portugal and Brazil at that time, and when he found that everybody came back, he dropped it.

Q. Just so I understand it -- I've just got a couple other questions on that and we're going to move on to another topic -- you were originally a Defendant in that Baylor case; true?

A. Correct.

Q. Your understanding is you were voluntarily dismissed from that case as a Defendant; true?

A. Correct. When you say voluntary, voluntary by the Plaintiff?

Q. Yes.

A. Okay.

Q. And then after being voluntarily dismissed by the Plaintiff, you then agreed to testify as an expert on behalf of the hospital; true?

A. Yes.

Q. But you ultimately didn't testify for

the reasons you have already stated; true?
A. Yes.
Q. What was the name of the case besides Baylor University as a Defendant? Who was the Plaintiff, the named Plaintiff?
A. When you're at Baylor and the Baylor faculty, there is no other name. It's Rothman.
Q. Roth?
A. R-O-T-H-M-A-N, Rothman.
Q. Mr. Rothman?
A. Yes.
Q. What was Mr. Rothman's first name?
A. I think it was Robert. I don't know for sure.
Q. Baylor is located in what county in Texas?
A. Harris.
Q. The other cases that you have been named as Defendants --
MR. FRASURE: Objection.
Q. -- were they up here in Summit County?
A. I believe they're in Summit because I'm in Summit County, yes.
Q. Do any of those cases have anything to

do with the diagnosis or treatment of any type of a nephritis?

A. Hard to answer that question.

Q. Again, without beating a dead horse with a stick, explain to me why it's hard to answer.

A. I can't remember the lady's name, but there was a lady that came to my office, she was the sister of one of our transplant patients, okay, she came in, she looked perfectly healthy, physical exam was perfect; she was fine. She had an ultrasound of her kidney that showed obstruction on the one side. I think it was the left. She stated she didn't want any tests run that would put her at any risk for further renal damage. That's what she said. And she qualified that by saying you're taking care of my sister, and I do know what I'm talking about, okay.

Now, that meant any IV contrast -- IVP, CT, to further delineate what the problem was, she would not agree to. We got lab work on her, which, as I recall, okay, was normal. To make a long story short, even though I scheduled her for further tests, she never showed up, and she never agreed to have the tests done.

Several years later, she had a nephrectomy done. I think it was here or at the Cleveland Clinic. I don't know which. So I don't know if -- when you say nephritis, that's inflammation of the kidney, literally translated. So what they found on path, I don't know.

Q. I take it in that particular matter, you were blaming the patient for not following up; is that true?

A. No. I contacted her, and she refused to have the test done, and it was clearly documented in my records, and the Plaintiff, the Plaintiff's attorney, when she copied my notes, failed to copy one of the notes, and when she saw it, that's when the case came unraveled.

Q. You blame the patient, though; true?

MR. FRASURE: Objection.

A. I don't blame the patient. She didn't do the test, and she didn't want the test. But we had contacted her and set that up.

Q. Now, the three cases that you have been sued up here in Summit County, have all of the cases -- have you been represented by the Buckingham, Doolittle firm?

A. I believe I have. There may have been -- I believe I have.
Q. Okay.
A. I think so.
Q. Has Mr. Frasure, other than the situation where he was covering for Mr. Banas, has he represented you in the past?
A. To the best of my knowledge, it's always been Mr. Banas.
Q. To the best of your knowledge, those cases are gone now?
A. Gone.
Q. Okay.
A. Now, see, you have just jinxed me.
Q. The five years or so that you have reviewed cases, you said that in the year 2000, you have reviewed three cases?
A. Yes.
Q. Does that include this case?
A. Yes.
Q. And one or two on average in the previous years?
A. I think there were one or two total.
Q. Have you ever testified in deposition as an expert witness up here in Ohio? In other

words, given a deposition similar to what you're going through right now.

A. As an expert witness?

Q. Yes.

A. Not yet.

Q. So this is the first time that you have given an expert deposition in a malpractice case up here in Ohio?

A. Yes.

Q. Is your deposition scheduled, to your knowledge, in any other cases that you are serving as an expert witness in?

A. No, unless you have some information that you haven't shared with me.

Q. Well, I don't. Can you tell me, over the five years that you have reviewed cases, what percentage have been at the request of the Plaintiff's attorney versus at the request of the Defense attorney?

A. Well, the three, the three this year. Two are on the Defense and one is the Plaintiff.

Q. As we go back over the five years, has it been pretty much two-thirds Defense, one-third Plaintiff?

MR. FRASURE: He said there were only

two more.
A. There's only five cases total. I think one was Plaintiff and one was Defense, but I don't --
Q. I thought you said one or two a year.
A. No. No. Total. I said the total.
Q. Five cases you have served as an expert in total?
A. I've been asked to review the case in five cases.
Q. Do you know Dr. Cola?
A. Not personally.
Q. You have hospital privileges at some of the same hospitals that he has privileges at?
A. I believe I do.
Q. You know him professionally?
A. I think we have shared some patients.
Q. He's referred some of his nephrology patients to you; correct?
A. To our group.
Q. What about Dr. Zarconi, do you know Dr. Zarconi?
A. Yes.
Q. Do you know him more than professionally?

A. Yes.
Q. Personal friend of his?
A. We're friends.
Q. Have you had occasion by circumstance or otherwise to have talked with Dr. Zarconi about this case?
A. No, sir, I have not.
Q. Do you hold Dr. Zarconi in high regard as a nephrologist in this area?
A. He's my competition.
Q. And I don't mean to be disrespectful or funny about it, but he can be your competition and you may feel that he's an excellent nephrologist, or he may be your competition and you have no opinion of him, or you may think that he's really a very good nephrologist.

So, notwithstanding him being your competition, do you hold an opinion as to his expertise in the area?

MR. FRASURE: Objection. Go ahead.
A. Yes.
Q. And what is that?
A. I think he's a good friend, fine human being, and a good nephrologist. I do hold him in high regard. Equal.

Q. Do you know any of the other doctors, just to try to cut to the chase, any of the other doctors, that have been involved in any aspect of Vickie's care as you have looked at the records in this matter?

A. Dr. Spoljaric, I probably know him like I know Dr. Cola; strictly professional basis, if there's a referral. Dr. Flauto has been one of the residents at Akron City Hospital, and basically those are the players I know. Harry Hoffman I've talked to. I've shared cases with him.

Q. Do you know whether any of Dr. Cola's patients are currently active patients in your practice here?

A. For a fact, I do not. I would assume so. When I say that, there's five of us in the practice. We go over several offices over four counties.

Q. Okay.

A. So there's a good bet that we have some.

Q. Have you personally been involved in the care of any of Dr. Cola's patients?

A. I do not recall that.

Q. You may have; you just can't say one way or another?
A. Right.
Q. What you can say is that Dr. Cola has made referrals to your practice group. Whether you were involved or not, that you can't say?
A. I believe that's true.
Q. Have you had occasion to talk to Dr. Cola at all since you have been involved in this case?
A. No, sir.
Q. And I take it that that would also include talking with him about matters unrelated to this case as well?
A. Haven't talked to him. With the short time, that's fairly easy to assure.
Q. The CV that Mr. Frasure sent over to me has a few publications on it.
(Discussion off the record.)
Q. The publications that are referenced in the CV that Mr. Frasure sent to me, there are five publications. Is that the extent of the publishing that you have done?
A. Yes.
Q. Anything submitted for publication?

A. Not at this time.
Q. Have you submitted anything in the past for publication that was rejected?
A. No.
Q. Just to focus me in, tell me what you understood your assignment to be as it relates to this case. What were you asked to do?
A. Reading Mr. Frasure's letter, it was my understanding that I was supposed to review the records that he sent me and give him a call and discuss them after I had read them.
Q. Were you asked to provide standard of care testimony as it relates to whether Dr. Cola met or fell below accepted standards of care?
A. I was asked to review the record and discuss the case. That's what I was asked to do.
Q. Do you hold opinions that you intend to offer at the trial as it relates to whether Dr. Cola did or did not meet the standard of care for a primary care physician?
A. I intend to give an opinion on whether I think he met the standard of care.
Q. And I take it your opinion is that he did meet the standard of care?
A. Correct.

Q. You weren't asked to provide opinions as it relates to the care of other doctors, were you?

A. I was asked to review the records and to discuss my opinion. It was obvious that, to me, Mr. Frasure told me he was representing Mr. -- or Dr. Cola, okay, and that Dr. Cola and Dr. Spoljaric were named as Defendants in the case. At the time I reviewed the records, I assumed that Dr. Cola and Dr. Spoljaric were the Defendants.

Q. You weren't asked to provide any opinions as it relates to the care provided either by Dr. Spoljaric or by any other physician, named or otherwise; true?

A. Specifically not asked.

Q. And in your report that you have written as of October 2, you didn't provide any opinions as it relates to the care provided by anyone other than Dr. Cola; true?

A. I don't believe I did. Yes, I addressed Dr. Cola because that was -- Mr. Frasure was the one asking me to review based on his defending Dr. Cola.

Q. You have not written any subsequent

reports expressing any additional opinions?
A. No. No.
Q. As you sit here right now, are you critical of any other doctors in terms of the care or management of Vickie Miglore?
A. No.
Q. Let's see if we can come to some agreement on some things and then we'll see what we can come to some disagreement on. Fair enough?
A. Fair.
Q. First, let me ask you to tell me what you believe caused her glomerulonephritis.
A. The one that was biopsied in March?
Q. Yes.
A. I believe it was rapidly progressive crescentic glomerulonephritis secondary to Wegener's.
Q. Can we agree that, according to the information that you have available and the evidence that has been provided to you that Vickie did not have any preexisting renal or kidney disease before the Wegener's granulomatosis caused the inflammation of the glomeruli?

A. No, I can't go along with that.
Q. Why?
A. Because I don't know that.
Q. Do you have any evidence to say to a probability that she had renal or kidney disease prior to the involvement caused by the Wegener's granulomatosis?
A. I feel it is possible.
Q. But not probable?
A. Can't render an opinion on that. I just don't know.
Q. Can we agree that it's not uncommon to see normal creatinine and BUN levels in early stages of glomerulonephritis?
A. Define normal.
Q. Within normal laboratory parameters.
A. Yes.
Q. Can we also agree that glomerulonephritis can be treated on an outpatient basis as long as the blood pressure and the creatinine and BUN are normalized or within normal limits?
A. That's a broad, broad statement. I'm sure you did that purposely. Some can be.
Q. Generally speaking, if the BUN and the

creatinine are within normal limits and the blood pressure is being treated, can patients be treated for inflammation of the glomeruli, generally speaking, on an outpatient basis?

A. I cannot say generally.

Q. More often than not.

A. Depending on the cause.

Q. What conditions would cause -- let me ask you: Are there situations where a patient has an early diagnosis of Wegener's granulomatosis that causes renal involvement such that the glomerulonephritis can be treated on an outpatient basis?

A. Are you saying once the diagnosis is established?

Q. Well, not necessarily once the diagnosis is established, but if Wegener's granulomatosis is the causative entity that leads to the necrotizing granulomatous changes that lead to the glomerulonephritis, but it's diagnosed at a point in time where the creatinine and the BUN are normalized and blood pressure is under control, can the glomerulonephritis, in that setting, be treated on an outpatient basis?

MR. FRASURE: You're assuming the

diagnosis is made?

A. That's what I want to ask you, because in your statement I think you said crescentic glomerulonephritis. By definition, to say that statement, you would have to have a biopsy. The biopsy would be performed in the hospital. So, I mean, I don't want to argue semantics, but in that particular case, that patient would be hospitalized at least for that biopsy, okay.

Q. Once biopsied, and assuming there isn't multi-system involvement that causes the patient to have serious complications from the Wegener's, can the patient, if diagnosed and having maintained normal BUN and creatinine levels, can that patient be treated for their glomerulonephritis on an outpatient basis?

A. If the diagnosis of Wegener's is established and there's no other acute target organ damage?

Q. Yes.

A. And you're just looking at the renal insufficiency from a bonafide biopsy demonstrating it's most likely due to Wegener's, and the BUN and creatinine are normal, under those circumstances, you could treat it as an

outpatient.

Q. If you diagnose, are fortunate enough to diagnose, a glomerulonephritis secondary to Wegener's at an early stage and treat it on an outpatient basis, same scenario that I'm describing, what is the standard treatment for glomerulonephritis?

MR. FRASURE: Secondary to Wegener's?

MR. MISHKIND: Yes.

A. When you said the same scenario that I'm describing, was that the one I described?

Q. Yes.

A. The one I just described, to say the same thing, the standard therapy would be steroids and cytoxan.

Q. Would the steroids and cytoxan be for the Wegener's granulomatosis or for the glomerulonephritis?

A. You -- I'll let you finish. I need some more clarification. You just gave two different scenarios. At first you said we have a diagnosed Wegener's granulomatosis with primarily renal disease. That seems to be -- well, the renal function based on the laboratory, the BUN and creatinine are normal, okay. That was the

first thing that you stated. That's what I understand the hypothetical is.

Your second question is: Are we treating Wegener's or the renal disease. So I'm confused what you want to treat.

Q. If you diagnose Wegener's and there is kidney involvement but no upper and lower respiratory involvement, no skin involvement, et cetera, eyes, do you treat Wegener's on a prophylactic basis to prevent the involvement of other systems while you are treating the system, in your situation, the kidneys, that have been affected by Wegener's?

A. In the case that you just outlined, I would submit to you you do not have a case of Wegener's. You did not make the diagnosis of Wegener's.

Q. So you have made the diagnosis of glomerulonephritis?

A. Presuming -- yes. If you had a lab test, yes, you made a diagnosis of glomerulonephritis.

Q. Why do you say that you would not have made a diagnosis of Wegener's if you just have kidney involvement?

A. Kidney involvement of what?
Q. Necrotizing glomeruli secondary to Wegener's.
A. No. Why would you say that, you have Wegener's, when you just have disease in the kidney that is a glomerulonephritis?
Q. I thought the scenario, doctor -- maybe you and I are not talking the same language -- the crescentic necrotizing glomerulonephritis that you have characterized as what would be secondary to Wegener's, I've asked you if that was the only system involved.
First, let me take a tangent off that. You can have kidney involvement and no other involvement secondary to Wegener's; true?
A. No.
Q. You're saying you can't?
A. No.
Q. You have said no to both questions. What are you telling me, that you have to have more than one system involved?
MR. FRASURE: If you have Wegener's?
MR. MISHKIND: Yes.
A. How do you make the diagnosis of Wegener's? What are we talking about here? Are

we making the diagnosis of Wegener's based on what the constellation of target system involvement is? If, on the other hand, you and I change the rules and say we are talking about a rapidly progressive glomerulonephritis that I biopsy, and it shows crescentic glomerulonephritis, the differential is not just one disease; there's a multitude of diseases that can cause that.

Q. All right, doctor. Let me move on to a different area, because I can tell we're not going to get anywhere with this, and I don't mean to be disrespectful.

A. Okay.

Q. I'm just not sure that we're --

A. Okay.

Q. Let's talk about glomerulonephritis, whether it's caused by Wegener's or caused by some other condition, okay?

A. Okay.

Q. How do you go about diagnosing glomerulonephritis?

A. It's very open-ended. I look at the urine, I look at the blood work. To pin the diagnosis down, in most cases, in most cases, a

biopsy would be needed, pathologic diagnosis.

Q. Are there certain titers that you look at that are characteristic of a nephritis involving the glomeruli?

MR. FRASURE: With or without Wegener's now?

MR. MISHKIND: I'm talking about, in general, in terms of diagnosing glomerulonephritis.

A. Glomerulonephritis is a broad term. You can diagnose a glomerulonephritis and then try to be more specific and try to get it in a different category, or glomerulonephritis would be either a primary or a secondary disease. Do you understand what I'm trying to say?

Q. Why don't you define for me the difference between primary and secondary.

A. Primary glomerulonephritis is just involvement of the glomerulus and the kidney.

Q. Okay.

A. Secondary is due to systemic disease, where the kidney is only one organ that's affected of a systemic disease.

Q. When you have a systemic disease, and I don't mean to simplify it, oversimplify it, in

the evolution of that systemic disease, there is usually one system that is invaded first, is there not?

A. Sometimes.

Q. And certainly with Wegener's, it is a systemic disease; true?

A. Correct.

Q. And in Wegener's, frequently you see upper and lower respiratory involvement as the first system that is involved; true?

A. Correct.

Q. You can also see renal involvement as the first system involved in Wegener's as well; true?

A. Less common.

Q. I'm not saying that it is -- it's more or less, but it certainly is --

A. It's certainly been recorded.

Q. It happens?

A. Yes.

Q. And simply because you have renal involvement as the presenting feature of Wegener's, you can't say it's not Wegener's because the presenting system involvement wasn't upper or lower respiratory; true?

A. Rephrase that.
Q. Sure. The more common characteristic, hallmark, if you will, of system involvement is upper and lower respiratory secondary to Wegener's granulomatosis; true?
A. True.
Q. And then other systems are known to be implicated as well; true?
A. True.
Q. More common system is upper and lower respiratory as the first presenting system; true?
A. True.
Q. But that doesn't mean that, while it's less common, that kidney or renal involvement isn't at times the first presenting system; true?
A. True.
Q. And I guess my question now, tying it all together is: Simply because you have renal involvement as the first presenting system shouldn't cause a clinician to say it's not Wegener's because it's more common to have it in the upper or the lower respiratory tract; true?
A. I think you have to be careful with

the implications of what you're asking me, and I'm sure you are. From my point of view, okay, diagnosing Wegener's, I think you're correct, that something hits first, most of the time, okay. But there's a myriad of problems out there in each of these target organs. It isn't fair, or reasonable, to jump off to a systemic disease such as Wegener's based on initial presentations necessarily of renal disease.

Q. But it's not unheard of and it's not reported and it certainly is seen that renal disease will be the first system involved, and I'm not suggesting that you necessarily stop at that point, but if you have renal involvement, you can't automatically close your eyes to the prospect that renal involvement may be secondary to Wegener's granulomatosis; true?

A. That would be in retrospect.

Q. No; looking at it prospectively. If you had renal involvement, are you going to suggest to the jury that if you have renal involvement and you don't have other systemic involvement initially, that you can rule out Wegener's granulomatosis?

A. No, but I may not be able to make the

diagnosis.

Q. There are other things that need to be done following --

A. I may not be able to make the diagnosis.

Q. And you may be, depending upon what other tests are done; true?

A. No.

Q. Why do you say you may not be, and then when I give you the opposite you say you wouldn't be able to.

A. Because, see, you asked. I deal with that all the time, okay. I'm on that side, all right. Let's see. Let's say a patient presents with renal disease, any of these, okay, isolated. We have already said that that could be the first target organ of Wegener's, okay. You don't know at that point that that's what that is.

Q. Okay.

A. Wegener's, by definition, is a systemic disease, okay.

Q. What do you need to do to know whether it is Wegener's, if the target area is renal involvement? What steps do you have to take?

A. A lot of times time.

Q. Well, in addition to time, what else do you have to do? If you have got renal involvement, what steps do you have to take to make -- what algorithim, if you would, would you follow in terms of working the patient up if you have potential renal involvement and no history of renal or kidney disease in the past?

A. It depends upon what the presentation is.

Q. Okay.

A. And that varies, and you and I are going to talk from now until forever, basically because it depends on what abnormality are we presenting, okay. Is it proteinuria, is it hematuria, is it leukocytes? Is there a minor elevation in the creatinine from .9 to 1.3, all within normal limits?

I can see from the other point of view, if we look at Wegener's as a category and say, okay, you grant me that, you can have an initial presentation of Wegener's being a kidney, no other findings, I said yes, but the flip side is not necessarily the same. We're not going to come to the same point.

Q. I'm not sure that -- I think you may be reading more into my question than what I'm asking.

A. I'm sorry.

Q. I hear what you have just said, and let me come at it a different way hopefully so we can finish this deposition today.

Would you agree that if glomerulonephritis is diagnosed and treated before permanent renal function has taken place, that it can be treated without the need for dialysis?

MR. FRASURE: Wegener's?

MR. MISHKIND: Glomerulonephritis.

A. Before permanent damage? You said permanent function.

Q. Permanent renal dysfunction has taken place.

A. There's all sorts of degrees of permanent damage.

Q. Tell me what would have to take place in the diagnosis and treatment of a patient with glomerulonephritis in order to avoid the need for dialysis.

A. You would hopefully have to arrest the

disease before you get to a critical diminution in the glomerular filtration rate.

Q. And how would that be manifest? What would you be looking at to determine whether or not you have arrested the inflammation before that critical stage occurs?

A. You would look at a creatinine clearance clinically.

Q. What type of creatinine clearance -- would that be based upon a 24-hour urine?

A. More than likely, yes.

Q. If you looked at a creatinine clearance as well as the serum creatinine, what level would you need to avoid, if you will, before you get to that critical point where the patient needs dialysis?

A. Generally speaking, a creatinine clearance below ten would allow one in this country to dialyze a patient.

Q. Do you wait to put a patient on dialysis until their creatinine clearance is below ten?

A. Loaded question. Sometimes yes, sometimes no.

Q. At what level do you take a patient

off of dialysis? When they're above ten?
A. Correct. Usually.
Q. What is your understanding of the creatinine clearance that Vickie has currently?
A. The number?
Q. Yes.
A. 32, 34, right around there.
Q. What is your understanding, based upon your review in this case, as to what level she was at when she went on dialysis?
A. I don't recall that figure. I don't know -- I honestly don't know, without reviewing the records again, whether they got a creatinine clearance before they started her on dialysis.
Q. Why did they start her on dialysis?
A. They felt she was uremic.
Q. And was she?
A. I wasn't there.
Q. Well, you have reviewed the records. Do you see evidence that would suggest a need to put her on dialysis?
A. I would assume that Dr. Zarconi made the right diagnosis and she was uremic and needed dialysis. I certainly would go that far.
Q. Define for me uremic.

A. Uremia is azotemia that's symptomatic from renal failure.

Q. And at what level, if you're looking purely at the serum creatinine and the BUN, at what level would you need to be at before you would consider a patient to be in renal failure?

A. It depends on the rapidity by which it happens. So that level may be altered in acute renal failure. It's not only BUN, creatinine under those circumstances; it's also the symptoms of the patient and the findings of the patient.

Q. So you have to take into account the renal panel as well as the signs and symptoms the patient demonstrates?

A. Yes.

Q. Again, looking at it in terms of the renal panel, what level of creatinine clearance in a 45 or 47-year-old female would you be concerned about that that patient is advancing into or is in fact in renal failure?

A. You would like to see a creatinine -- creatinine clearance is much more specific, but creatinine clearance less than 10. That's what you would like to see. Now, short of that, sometimes you don't get a creatinine clearance

because you assume with the symptoms a constellation of uremic symptoms, if the serum creatinine was seven, eight, and I'm throwing out ballpark figures. It depends on the muscle mass of a patient. I've never seen this person. But, again, in terms of ballpark figures, creatinine seven or eight and symptomatic, certainly you could make a case for dialysis.

Q. Let's talk about hematuria. Urine dipstick, would you agree that that is not sensitive enough to be relied upon to determine whether or not there exists red blood cell casts?

A. That it is -- please, I'm sorry, can you give me that again. I spaced out.

Q. Sure. Before you spaced out, my question was: Would you agree that a urine dipstick done in an office is not sensitive enough to determine whether or not the hematuria that is detected by the urine dipstick, whether or not there are red blood cell casts in the urine?

A. That's a hard question to answer in that urine dipsticks, assuming they're not out of date, fresh out of the bottle, will be positive

with one to two red cells for high powered. Red cell casts are accompanied by red cells in the urine.

Q. Well, will a dipstick distinguish myoglobinuria or hemoglobinuria from hematuria?

A. No.

Q. Will a dipstick differentiate morphologic changes or dysmorphic changes in the urine?

A. No.

Q. A urine microscopy or microscopic urinalysis needs to be done to detect morphology or dysmorphia of the red blood cell or the red blood cell casts; true?

A. Generally speaking.

Q. And if you had dysmorphic changes as well as red blood cell casts on microscopic urinalysis, would you agree that that is characteristic of renal involvement?

A. Red blood cell casts, by definition, are characteristic of renal disease.

Q. And morphologic changes that would be detected from microscopic urinalysis are also characteristic of the type of hematuria that you would see in renal involvement; true?

A. Controversial.
Q. You're not suggesting that you would see morphological changes --
(Interruption.)
(Record read.)
Q. -- in red blood cells that are produced from the lower urinary tract, are you?
A. You picked right up on the end of that, okay.
Q. I did.
A. My understanding of morphologic changes in the red cells, okay -- this has been looked at -- my understanding is that first morphologic or dysmorphic red cells in the urine were indicative of upper urinary tract disease.
Q. Renal?
A. Renal.
Q. Okay.
A. Whereas nice, regular red cells were more indicative of lower urinary tract.
Q. Okay.
A. The problem with that is when you actually do the microscopic analysis, as I have, okay, on most of the patients I see, nothing is in black and white. There is a percentage that

are dysmorphic; there are a percentage that's not. Therein lies the controversy. It's not black and white. Again, that's why some have -- it's fallen by the wayside for some and others it's not.

Q. Let's talk about in general then. If you are looking at glomerular versus nonglomerular origin for the hematuria, okay --

A. Yes.

Q. -- number one, when you look at microscopic urinalysis, you are looking for red blood cell casts; correct?

A. Correct.

Q. And red blood cell casts would be more commonly associated with glomerular or kidney involvement than in the urinary collecting system; true?

A. Red blood cell casts indicate glomerular disease.

Q. Now, in this particular case, there was no microscopic urinalysis done; true?

A. Yes. This case spans over --

Q. When Dr. Cola was responsible for the care and treatment of this patient, he did a urine dipstick; correct?

A. In August.
Q. In August.
A. That's when you're referring to.
Q. Do you know of any others that he did?
A. I'm referring to the August. He's followed this patient for a long time.
Q. The August one is what I'm referring to. At that time, he did a urine dipstick; correct?
A. Correct.
Q. And there was three plus blood; correct?
A. Correct.
Q. That three plus blood told whether or not there were red blood cell casts in the urine; correct?
A. Correct.
Q. In order to determine whether or not there was red blood cell casts in the urine, he would have had to have done a microscopic urinalysis; true?
A. Correct.
Q. If the microscopic urinalysis had been done and it showed red blood cell casts in it,

that would be consistent with hematuria of a glomerular origin as opposed to a nonglomerular origin; true?

A. If it showed that, yes.

Q. If it showed dysmorphic or distorted red blood cells, while controversial, one more often thinks of dysmorphic changes in the red blood cells to be emanating from the kidneys as opposed to the lower urinary tract; true?

A. It raises more of a suspicion.

Q. And if one has hematuria of -- strike that.

The difference between gross and microscopic, just so that when we get before the jury, you don't need to have gross hematuria, something that you or I would see in the urine, for a clinician to be able to press the right buttons to lead to a diagnosis of either glomerular or nonglomerular involvement; true?

A. You do not need gross, yes, correct.

Q. In fact, if you have gross hematuria, you start thinking of other things aside from whether or not you have got either the blood caused by the lower urinary tract or renal involvement; true?

A. No, I don't go that far.
Q. It expands the list of things that you would think of, would it not?
A. Gross?
Q. Yes.
A. I don't know if I'll go that far.
Q. It would include trauma, would it not?
A. Microscopic can, too.
Q. In any event, if you have three plus blood in the urine, you would agree that that is something that needs to be investigated; true?
A. Followed up.
Q. And followup on three plus blood would include microscopic urinalysis; true?
A. I don't know if it has to.
Q. Certainly that would be a reasonable and prudent way to investigate three plus blood in a urine dipstick; true?
A. Certainly it would be reasonable.
Q. And if a reasonable and prudent physician does follow up and does a microscopic urinalysis and there are red blood cell casts, then one has to think in terms of glomerular versus lower urinary tract involvement; true?

MR. FRASURE: The general practitioner or someone down the line, just so we're clear?

MR. MISHKIND: Just a general medical standpoint.

MR. FRASURE: Okay.

Q. Primary care doctors, internists, are aware or should be aware of, when one sees red blood cell casts, whether or not that is indicative of a urinary tract infection or indicative of renal involvement; true?

A. I would hope.

Q. This is not brain surgery when it comes to evaluating --

A. Thanks.

Q. -- in terms of evaluating whether the information is from hematuria in a dipstick and then microscopic urinalysis as a followup; true?

A. You asked several questions and rephrased it, and I let you finish, but can I answer the one I think you asked?

Q. Sure. If you know what it is.

A. You'll tell me if it isn't, I'm sure.

The question originally was if you have red blood cell casts, that differentiates between glomerular or lower urinary tract. That

differentiates between glomerular and extraglomerular disease.

Q. Okay.

A. There's a difference between those two.

Q. But if you have red blood cell casts, you're not going to be thinking urinary tract infection is the most likely cause; true?

A. Correct.

Q. So that if you do not have leukocytes, that would even lead you further, if it wasn't enough just having the red blood cell casts, to conclude that this patient doesn't have a urinary tract infection; true?

A. I have a problem with that, okay. You'll see pyuria, you can see bacteria, hematuria, pyuria. They don't all have to coincide at once, so you may not have the pyuria and still be infected.

Q. But you're not going to be able to detect that with a urine dipstick; correct?

A. Detect what?

Q. Well, the lack of leukocytes on a urine dipstick, while it leads you at least to surmise that there is probably not an infection,

without doing a microscopic urinalysis, you can't determine whether or not there is pus and bacteria that would be consistent with an infection; true?

A. The leukocyte esterase dipstick is pretty good, okay, so if it's positive, it's -- if it's negative, it's less likely that you're going to have leukocytes.

Q. So if the urine dipstick is negative for leukocyte ester --

A. Esterase.

MR. FRASURE: That's one we don't know.

A. That's one of the enzymes of the leukocytes. That's how it detects it.

Q. If it's negative on the urine dipstick, does that lead you to rule out or to be less concerned about infection?

A. It leads --

Q. Go ahead. I'm done.

A. It leads me to be less suspicious that there's white cells in the urine, no question about that.

Q. White cells in the urine would be consistent with the urinary tract infection;

true?
A. Among other things.
Q. What would some of the other things be?
A. Interstitial nephritis, reflux with stone disease. I mean, there's a lot of different things that pyuria can give you.
Q. Now, three plus blood in the urine on a urine dipstick is a serious amount of urine on a dipstick, is it not?
MR. FRASURE: Blood?
Q. A serious amount of blood on a dipstick, is it not?
A. It's positive.
Q. And it's positive in that it needs to be evaluated; true?
A. Yes.
Q. And especially, I think you told me before, you need to take into account the patient's signs and symptoms as well; correct?
A. Yes.
Q. So that if you have signs and symptoms that are -- strike that. I'll get to that in a moment.
So when you have hematuria, you would

certainly agree that a thorough history and physical examination is invaluable in arriving at an etiology for the hematuria; true?

A. Yes.

Q. If hematuria is of glomerular origin, the way that you're going to determine that, in the diagnostic workup, would be to look at a microscopic urinalysis; true?

A. Yes.

Q. And then, if you have microscopic urinalysis done and you have red blood cell casts, you have dysmorphic changes that suggest glomerular origin, would the next series of tests include 24-hour urine collection and serum BUN and creatinine levels, repeat serum BUN and creatinine levels?

A. If we had a urinalysis, a microscopic urinalysis, and you saw RBC casts, and when you said dysmorphic cells, I presume you mean dysmorphic red cells?

Q. Yes.

A. And you did not have any other blood work, your question was would you get a BUN and creatinine and a 24-hour urine; is that right?

Q. Yes.

A. May or may not get the 24-hour urine; would get the BUN and creatinine and electrolytes, yes.

Q. Can we agree that in a microscopic urinalysis that you performed at Barberton Citizen's Hospital on August 21, it would have been helpful to determine whether there was a continued presence of hematuria in Vickie Miglore?

A. On what date?

Q. On August 21 when she had -- she had the urine dipstick done on August 13. She was sent to Barberton Citizen's Hospital for a number of tests. Would it have been helpful to have done a microscopic urinalysis on August 21 to determine whether or not there was continued presence of blood in her urine?

A. It may or may not.

Q. Well, would it have been harmful to the patient to have done it?

A. No, it would not have been harmful, no.

Q. If there was a microscopic urinalysis showing abnormal morphology or red blood cell casts, then that would have led one to consider a

higher likelihood of kidney involvement than of a urinary tract involvement; true, lower urinary collecting system?

A. Kidney disease, yes.

Q. Now, you know that when Dr. Cola sent Vickie to Barberton Citizen's Hospital, he or someone from his office crossed off urinalysis, meaning the microscopic urinalysis and culture and sensitivity, from the tests that he wanted performed on her; true?

A. I have some questions on that. Doing these tests and doing them over lab care or at Barberton, if you get a urinalysis, and most of these hospitals that are out there, check off UA. If they dipstick it, they may or may not do a microscopic. That comes from, really, my experience. You may find that appalling, but that's true.

Q. I'm not sure I just followed your statement. Repeat it, if you would.

A. If I check off urinalysis, routine UA.

MR. FRASURE: On the requisition slip?

A. On the requisition, most of these hospitals won't routinely perform the microscopic evaluation of the urine.

Q. Well, is it your understanding, based upon your review in this case, that Dr. Cola checked UA and culture and sensitivity?

A. It is my understanding he did not at that time.

Q. All right. So what you're suggesting is that had he requested a microscopic urinalysis and a culture and sensitivity, the people at Barberton Citizen's Hospital may just have done the same thing that he did in his office?

A. No, but I am suggesting if he checked off UA, they may have done the same thing.

Q. But you don't know that, do you?

A. With reasonable certainty, I do.

Q. So you're going to suggest the people at Barberton Citizen's Hospital, if she had been sent over with information from Dr. Cola that she had hematuria, three plus blood in her urine, and he wanted a microscopic urinalysis and checked off or circled urinalysis on the requisition, that the people of the lab would have done essentially the same thing that he had done in his office?

A. You changed the question, okay. If he said -- if he called up the lab and said I got

three plus hematuria, and I want a microscopic evaluation done by the pathologist, they would have done it.

Q. Okay.

A. If he writes out a bunch of -- or checkmarks a bunch of orders, SMA-7, CBC, UA, the UA would consist of a dipstick urine.

Q. So it's incumbent upon the clinician, if he wants certain tests to be done that are indicated, that he do more than just check off that little requisition slip; true?

A. Or somebody.

Q. Or somebody in the office; true?

A. True.

Q. Sometimes a doctor is busy and he has to rely on his office staff?

A. I do, yes.

Q. That's what you do in this office; right?

A. I have to preface this by saying every urine -- I'm a nephrologist, so every urine I look at as a new patient. Every new patient that comes in the office I do a microscopic myself.

Q. Again, had sufficient information been conveyed that a microscopic -- let's take the

scenario that they had just done -- another urine dipstick similar to what Dr. Cola had done and it had come back with three plus blood, further, you would now have on August 13th and August 21, you would now have two positive findings of three plus blood, and you would need to do further followup to determine the source of that hematuria; correct?

A. Yes.

Q. But let's assume that a microscopic had been done on August 21 and it showed continued hematuria, and there was presence of abnormal morphology and red blood cell casts; again, that scenario would be suggestive of some renal or glomeruli involvement; true?

A. Qualified, yes.

Q. Like being kind of pregnant?

A. No. But --

Q. I'm here to find out what you're going to say at trial, so tell me why you qualify it.

A. Because you can send a urine with RBC or white cell casts to the lab routinely, okay, and it sits on the shelf, or it sits in the lab after they clock it in, and the casts will degrade. It's been my experience, and I'm

certain you can ask -- and I'm sure you will -- Zarconi, if you really want to know about RBC casts, okay, with real certainty, you have to do the specimen yourself and know what you're looking at, okay. Many times in the labs, they will miss it, routine labs, microscopic, because they sit too long.

If I tell you -- let's say I see you, and we're worried about this, and let's say you come in with a diagnosis of glomerulonephritis, you pee into a cup, if I don't take that down, spin it down right then and there, as time goes on, the yield of demonstrating those casts go down.

So that's why it's a qualified yes, because I've had this many times happen to me; get a patient referred and you get a Barberton lab, Medina, and if you think General or Summa are any better, choose your lab, they deteriorate.

Q. All right. All things being equal, though, if a lab does a microscopic urinalysis as it should be done within laboratory standards and it yields -- and there's continued hematuria and it yields evidence of abnormal morphology, or red

blood cell casts, that should cause a reasonable and prudent practitioner, with that information, to consider that the patient has some type of kidney involvement or kidney disease going on; correct?

A. The laboratory standard is too lax to pick that up routinely.

Q. Do you know what the laboratory standards are for Barberton Citizen's?

A. I'm saying in general. They got -- you get a urinalysis, you take the urine down, you send it out to these labs, and they just analyze what it is. They're up to their standard. If they spin it down at two to 3,000 RPMs for five minutes, that's the standard, that's the procedure that you use. They have no control over how long the specimen has set in the doctor's office or in the lab.

Q. Let's approach it from a different perspective. Dr. Cola didn't order a microscopic urinalysis, did he?

A. To my knowledge, no.

Q. We don't know what it would have shown on August 21, had he done it, whether it would have been because of laboratory problems or

otherwise; correct?
A. Say it again.
Q. He didn't order a urine culture either, did he?
A. To my knowledge, no.
Q. He did not order a renal panel either, did he?
A. I thought he got a renal panel. Can I check the records again?
Q. Sure.
A. All right.
MR. FRASURE: It's the next one down.
Q. While you're looking at that, I think you can probably look for it and answer my next question. What would be included in a renal panel?
A. Or sorry. Renal panel, as defined by City -- they vary. But at City, sodium, potassium chloride, bicarbonate, CO2, which is bicarbonate; that's how they measure it, BUN, creatinine, glucose, plus or minus calcium, depending on the lab, and albumin in some renal panels.
Q. Now, looking at the labs, did he obtain a renal panel?

A. He obtained more than that.
Q. Do you know why -- is that a good thing to have done at the lab?
A. Is it a good thing?
Q. I mean, is that helpful information?
MR. FRASURE: What he ordered or --
MR. MISHKIND: No. What was done.
A. Is this helpful?
Q. Yes.
A. Yes.
Q. Are you aware of whether or not Dr. Cola, in his requisition, in fact asked for a renal panel or not?
A. I saw that. Where is it? I did see that someplace.
Q. Let me show it to you just to save some time.
A. Okay. Thank you.
MR. FRASURE: Here it is.
A. He ordered a -- he crossed off renal panel, and he ordered a Chem 23, which encompasses the renal panel.
Q. He crossed off urinalysis and crossed off urine culture; correct?
A. Yes. Let me see it. Yes.

Q. Do you know whether it was Cola that crossed it off or whether it was someone from his office?

A. I have no idea, sir.

Q. While we're talking again about the dysmorphic red blood cell casts, would you agree with this statement: That hematuria with dysmorphic red blood cells is virtually diagnostic of glomerulonephritis?

A. No, sir.

Q. You would disagree with that. And the literature that you have acknowledged as being generally reliable, that you have reviewed, you believe would support that contention as well?

A. Dysmorphic red cells, in the text, dysmorphic red cells usually indicate upper urinary tract disease.

Q. Which is renal, which is kidney?

A. Right. But didn't you say glomerular?

Q. Yes.

A. That's why I disagree.

Q. Well, let's concentrate on the kidney as opposed to a UTI.

A. Okay.

Q. Which would be the urinary collecting system, the bladder and distal.
A. Okay.
Q. Can we agree that if a urinalysis is done and it shows dysmorphic red blood cells, that that is virtually diagnostic of kidney involvement?
A. No.
Q. Again, the literature that you have acknowledged to be generally reliable, that you have reviewed, you believe would support that contention?
A. They haven't addressed that.
Q. Certainly, we can agree that hematuria by dipstick does not distinguish microscopic bleeding which is registered as three plus that emanates from the kidney substance itself versus bleeding distally into the urine or the bladder or the urethra?
A. No question about it.
Q. In your report, you indicated that an earlier diagnosis would likely have resulted in less kidney damage?
A. Yes, sir.
Q. Tell me what you mean by that, with an

earlier diagnosis.

A. If you have crescentic glomerulonephritis, biopsy-proven crescentic glomerulonephritis, the disease itself, whenever it starts, may go from weeks to months to end stage. Obviously, the sooner you see that and diagnose it, the more likely you are to stop it before it progresses to end stage. There are exceptions, but the chances are better that you're going to stop it.

Q. What is your definition of end stage renal disease?

A. Dialysis-dependent or needing some modality to support your life long term.

Q. And the dialysis-dependent is this ten creatinine clearance?

A. Roughly, yes, sir.

Q. Is it fairly remarkable that Vickie Miglore was able to come off dialysis given the extent of her disease?

A. I'm happy for her.

Q. I'm not suggesting that we all aren't. But isn't it fairly remarkable from the standpoint of patients that experience this kind of injury to the kidney for her to be off

dialysis at this point?

A. I don't know if it's remarkable, but I'm -- how do you want me to answer? I'm happy that she is. Am I astonished? Is that what you're asking? No.

Q. She has permanent renal dysfunction; correct?

A. Correct.

Q. The earlier that her glomerulonephritis had been diagnosed, the better; true?

A. The better chance you have. Better chance, not necessarily the better outcome.

Q. But you indicate, and I believe you stand by your statement, that earlier diagnosis would likely have resulted in less kidney damage; true?

A. True.

Q. Do you have an opinion in this case, based upon your review, as to when an earlier diagnosis could have been made?

MR. FRASURE: Within the standard of care or --

Q. Based upon the review of all the medical information, when do you believe an

earlier diagnosis was there to have been made, regardless of by whom, if you have such an opinion?

A. Give it to me again. Rephrase it.

Q. Tell me when you believe that the crescentic glomerulonephritis could have been diagnosed based upon all of the information.

A. I don't have enough information. Based on the information I have, I would have to assume March. We're talking crescentic glomerulonephritis.

Q. Well, when do you believe that there was sufficient evidence to suspect renal involvement?

A. I don't know that. I honestly can't say I know that.

Q. And part of that is because there weren't tests conducted including microscopic urinalysis and further studies to explain the cause of her hematuria; true?

A. True.

Q. So had those tests been done, you would be in a better position to say when, if at all, before March such a diagnosis should have been made and to what extent it would have

impacted her kidney damage; true?
A. No.
Q. Tell me why.
A. Could have. Not should have.
Q. Would persistent hematuria on repeat urine dipsticks demonstrate the need for microscopic urinalysis?
A. Standard of care would be that the patient should be evaluated, in this community.
Q. And that evaluation with the microscopic urinalysis can be initiated by a primary care doctor; correct?
A. The microscopic urinalysis?
Q. Yes.
A. Yes.
Q. In patients that have unexplained hematuria subsequently evaluated by microscopic urinalysis that have glomerular involvement or renal involvement, not all of them have proteinuria, do they?
MR. FRASURE: At what point?
MR. MISHKIND: At the early stages of the diagnosis.
Q. In other words, if you have three plus blood, you do a microscopic urinalysis, you

suspect renal involvement because of the red blood cell casts as well as the dysmorphic changes, you don't always have protein spilling out into the urine at that time; correct?

A. Well, up to 150 milligrams in a 24-hour urine is considered normal, so you always have some.

Q. But it's not always going to be picked up first by a urine dipstick, is it?

A. Protein on a dipstick is fairly sensitive, but it depends upon what protein and it depends on the concentration or the specific gravity of the urine, if it's a dilute urine versus concentrated urine.

Q. Certainly the lack of protein in the dipstick shouldn't cause someone to rule out renal involvement in this case; true?

A. Shouldn't cause anyone to rule out renal involvement, true.

MR. FRASURE: Is that a statement or question, for the advantage of the court reporter?

Q. You restated my question, and you agreed with it; true?

A. I agreed with it, yes. Cannot rule it

out.

Q. And would you agree that in certain types of glomerulonephritis you rarely see protein in the urine when confronted by three plus hematuria as the initial presentation?

A. I don't go with that. I won't agree with that.

Q. So more often than not you will see protein?

A. Some.

Q. Some, okay. But the absence of it doesn't cause you to say this is not kidney in origin; true?

A. Correct. That's true.

Q. If one is going to work up a patient for an acute nephritis as a cause of hematuria, first three plus blood can be a laboratory finding consistent with an acute nephritis, inflammation of the kidney; true?

A. Yes.

Q. We've covered that.

A. Yes.

Q. Whether it's from the glomeruli, whether it's from the tubules, whether it's from the basement membrane, whatever, it is still an

inflammation -- it can be caused by an inflammation of the kidney resulting in three plus blood?

A. I believe that, yes.

Q. Would decreased urination or oligouremia, would that also -- would that be a sign or symptom that you would be concerned about in relationship to a patient that has three plus blood in their urine?

A. I'm sorry, I got caught up on your term oligouremia, and there's no such thing. Oligoria.

Q. Decreased urination, how is that?

A. Okay.

Q. Would decreased urination be a finding that would be consistent with acute nephritis?

A. May or may not be.

Q. Would it be a finding that would be consistent with acute nephritis in a patient who has three plus blood in their urine?

A. May or may not be.

Q. But certainly it's a factor that is seen in patients that have acute nephritis?

A. Nonspecific finding, maybe. Nonspecific.

Q. Edema or swelling of the extremities, is that also a finding that is consistent with acute nephritis in a patient that has three plus blood?

A. And no other findings?

Q. As well as decreased urination.

A. And no other findings?

Q. Well, let's add in anorexia.

A. You're entering a lot of different things now. Assuming the albumin was normal, no. Assuming the serum albumin is normal and assuming the patient doesn't have liver or congestive heart failure, no.

Q. Okay.

A. And not volume overload.

Q. If a microscopic urinalysis had been done in this case and it revealed red blood cell casts, would the standard of care have dictated performing a C-ANCA.

A. No.

Q. Would the standard of care dictate performing a C-reactive protein?

A. No, not necessarily.

Q. Would that have been a reasonable and prudent test to have ordered?

A. Not necessarily.
Q. Why do you say that?
A. There's a ton of other diseases out there.
Q. Well, isn't a primary care physician responsible for determining what most likely is causing --
A. Oh, I think that's a grandiose primary care physician that thinks that way.
Q. Why do you say that?
A. His responsibility would be to evaluate the patient to the best of his knowledge, and when he gets in over his head, make a referral.
Q. Certainly a primary care physician has a duty of responsibility to follow up on tests that he recommends and that he orders; correct?
A. Responsibility to follow up, yes.
Q. If a C-ANCA had been done and was positive, in this case, then a renal biopsy would likely have been performed?
MR. FRASURE: When, Howard? What time frame?
Q. If a C-ANCA had been done after microscopic urinalysis and it had been positive.

A. Positive for what?

Q. What would a positive C-ANCA suggest to you, doctor?

A. Positive C-ANCA would suggest to me that you have antibodies due to a neutrophilic cytoplasmic antigen.

Q. And what would that be consistent with?

A. In what context? Any context?

Q. Well, in a patient that has decreased urination, the patient that has -- if you want me to give you all of the symptoms, I will do that. Let me ask it to you this way so I could save some time, because I'll save this for when you and I chat at trial.

Would a positive C-ANCA, to you as a nephrologist, in a patient that has a history of three plus blood in their urine initially, that then has further microscopic urinalysis that defines the existence of red blood cell casts, morphologic changes in the red blood cells and a C-ANCA is performed that's positive, what does that suggest to you as a nephrologist is going on with this patient?

A. I got a glomerulonephritis.

Q. And what do you then need to do as a nephrologist in further evaluating or working that patient up?

A. With that data?

Q. Yes.

A. I'd look at the urine myself.

Q. Okay.

A. You already defined RBC casts. That's what you told me we have.

Q. Yes.

A. I would check the renal function, I'd check for protein at that time. It would be a dipstick or 24-hour urine, and then also I'd get an ultrasound of the kidneys. I'd order more serology, and, above all, first and foremost, even though I put it last, I'd get a detailed history and physical myself.

Q. Okay.

A. Because the history and physical is where you're going to solve many of these problems.

Q. In a patient that has three plus blood on urine dipstick that has complaints of sweating, not urinating as much, little appetite, inability to move, couldn't eat, sleep or talk,

severe neck pain, broke out in boils on their face and on their buttocks, what is that, that symptom complex, and the hematuria, what does that suggest to you is going on with this patient?

A. I don't know. I don't know, me, reading that note. You're referring to the 27th note or the 22nd? I don't know.

Q. Would you agree that the hematuria, the unexplained hematuria, needs to be evaluated based upon the context of the patient's symptoms, including what is perceived to be a worsening of symptoms from the time that the hematuria on dipstick was drawn two weeks earlier?

MR. FRASURE: Objection to the characterization. But go ahead.

A. I don't put much stock in the -- well, those -- that symptom complex. I'll just answer it this way. When I read that symptom complex, I was alarmed by that.

Q. Okay.

A. However, if you look at the previous ten years of notes, okay, and I'm not familiar with that patient, okay, and the notes that followed, because we do have the benefit of all

these depositions and what followed, a lot of those symptoms I don't know how much stock to put in them.

Q. Why do you say that?

A. Okay.

Q. I'm just trying to get your thought process.

A. It's scary if you get it.

Q. I'm still trying, doctor. We have been together for a couple hours and I'm still trying.

A. Those symptoms: Unable to move, unable to talk, unable to do anything, would have required -- I would have been in -- in a patient giving me those complaints, and that's what we have, correct me if I'm missing some of these, but that's, in essence, what we have, would have been alarming. I would have been alarmed by those, not knowing the patient, just at face value with those symptoms. Urine output, plus or minus, if you're not eating, if you don't eat or if you run, you're not going to put out as much urine as when you go out and have a few beers, okay. So the volume of urine doesn't bother me as much as the other symptoms.

However, that symptom complex that was reported, a month later it was never even brought up by the patient. I mean, I think if I had those symptoms, I'd still be talking about them ten years later. That's quite dramatic.

Q. But, doctor, just as we can't look at cases in retrospect, you can't look at cases a month later in terms of symptoms, and the question is: At that particular time on August 27 of 1997, those symptoms that you looked at, by your own admission, were alarming to you on August 27; true?

A. Those symptoms were alarming, but, also, the other thing that you have to take into account is she said they were getting better, and also this doctor had seen this patient for ten years, will you grant me, prior to that, and knows the patient a lot better than just your and my reading of this one note.

Q. Did Dr. Cola talk to the patient on August 27th?

A. To my knowledge, he did not. That was transmitted through somebody else. I think that's true.

Q. Knowing that these symptoms of

weakness, sweating, not urinating as much, has pains inside, little appetite, boils on the buttocks and the face, patient today can lift neck, open mouth and raise arms, but those symptoms, with the presence of unexplained hematuria from two weeks earlier, would you agree that this is a patient that needed to be evaluated on a prompt basis?

A. Should have been evaluated.

Q. This is a patient that needed to be seen as soon as was reasonably possible; true?

A. I would have seen the patient.

Q. And if it wasn't such that your day was crazy already with patients, would you have seen that patient on that day?

A. Ask me at 5:00 o'clock today and you'll get a better feel. No. I don't think they had to be seen that day.

Q. Would it have been reasonable and prudent if that patient wasn't seen that day to schedule the patient in the next day?

A. I would have asked the patient to come in.

Q. If not that day, within the next day? Would that have been reasonable and prudent?

A. It would have been reasonable.
Q. You don't see any evidence in this case, doctor --
MR. FRASURE: Did you answer the question, doctor?
Q. You answered my question, didn't you?
A. No. I had an addendum.
Q. You had an addendum to the question?
A. Addendum to the answer.
Q. Go ahead, doctor.
A. But I got to add that he knows this patient. He's got a better feeling for this patient than I do.
Q. I think you said that before.
A. Okay. All right. Go ahead.
Q. Doctor, there's no indication that Dr. Cola, from everything that you have read, intended to see this patient in the next day or within the next week or several weeks, was there?
A. I don't know if it was several weeks. I can't go that far. There was nothing that I saw that he intended to see the patient the next day. That's true.
Q. There's no indication that he intended

to advise the patient that she needed to have, within the next day or week, a followup on the hematuria in her urine, was there?

A. I don't know if I'd go that far, because he did plan on seeing her for the hematuria.

Q. Where do you get that from?

A. Her deposition stated that.

Q. Her deposition said that he planned to see her for the hematuria? That's your read of the deposition?

A. No. Her deposition stated he wanted to see her back for the abnormal labs. Abnormal. The big one that you and I have been talking about for the last couple hours is centered around the hematuria.

Q. Doctor, let me ask you this, to assume that which is the fact of the case, that the only information that was provided to Vickie over the phone was that there was an abnormal liver enzyme in the blood work. That was the only information that was provided to her.

A. How do you know that?

Q. Because that's the evidence in the case.

A. I don't know if that's true.

MR. FRASURE: I think we're disputing information.

Q. Can you tell me what information that you have from everything that you have reviewed that would suggest that Vickie was told that she had blood in her urine?

A. She was not --

Q. Okay.

A. -- to my knowledge told that.

Q. In fact, she was never told that she had blood in the urine from any time up until when she was actually in the hospital at Akron City when she learned about it?

A. I honestly don't know that.

Q. You have reviewed the records so you know that she developed a number of complications that required fairly lengthy hospitalizations at Akron City Hospital in March and April; correct?

A. Yes.

Q. Do you have an opinion, or do you intend to provide an opinion, at the time of trial, as to whether or not those complications first were as a result of her Wegener's granulomatosis?

A. Her presentation at -- in large, during the I believe it was Wadsworth and then a transfer to City Hospital, I would presume the majority of that is either due to the Wegener's or due to the complications of the treatment.

Q. Do you have an opinion as to which of the complications she developed, just to try to simplify it, because you have reviewed the records and you know that she went into respiratory arrest, you know she developed temporary blindness, you know she developed pancreatitis, et cetera; correct?

A. Yes, sir.

Q. Are you going to be able to tell the jury whether she would have, or whether, in your opinion, she would have sustained all of those complications anyway even if her Wegener's granulomatosis had been diagnosed earlier?

MR. FRASURE: Like in August or September?

Q. Back in 1997. In other words, if her diagnosis had been made back in 1997.

A. I don't know if it was present then.

Q. Let's assume that it was, and I understand that your opinion is that you don't

know whether it was or it wasn't; true?
A. That's true.
Q. You can't rule it out being present in 97; true?
A. Oh, true.
Q. Let's assume that it was there and that diagnostic tests were done that led to the diagnosis of Wegener's back in 97, okay?
A. Okay.
Q. If a diagnosis had been made of Wegener's back in 1997, can we agree that more likely than not the sequeli and the various complications with the respiratory symptoms, her blindness, the pancreatitis, and the multitude of complications she had, more likely than not would have been avoided had it been diagnosed back in 1997?
A. I cannot say that, sir.
Q. Are you going to testify that she would have experienced those things anyway, or you're just not going to offer an opinion one way or another?
A. She could have, she may not have.
Q. You don't have an opinion one way or the other?

A. I really don't. These people relapse.
Q. I understand that. But she has not relapsed as of this date, has she, since she was treated?
A. With the records that I've seen?
Q. Yes.
A. She was treated in March, seemed to get over this, and then was again hospitalized in April.
Q. But since --
A. If you want to say that's a relapse, okay. If you say it's a continuation --
Q. She had a very high dose of corticosteroids administered to her when she had her first diagnosis of Wegener's; correct?
A. She had standard therapy.
Q. The Solumedrol that she had, did you happen to notice the dosage of Solumedrol that she received?
A. I don't recall it offhand, but I would probably say it was about a gram.
MR. FRASURE: Look if you want to.
Q. Let me suggest this to you, and you tell me whether this sounds accurate, okay, just try to save some time.

A. Here it is.
Q. Was the initial treatment including the Solumedrol?
A. Yes.
Q. Was it 30 milligrams intravenously every 12 hours on admission?
A. I'm looking at the ones that you were referring to. The initial admit orders does not have steroids in it that I see on 3-11-1998.
Q. On the 7th of April, was she given one thousand milligrams of Solumedrol intravenously as a bolus?
A. 7th of April?
Q. Yes.
A. She was given that before that, but if that's what you want to go to.
Q. And continued to receive a thousand milligrams intravenously every day until the 12th of April?
MR. FRASURE: April is in the black book.
A. But I remember seeing that. That's when they stopped the, if I remember correctly, they stopped the cytoxan during that time, didn't they?

Q. Would they have stopped the cytoxan because of the extent of her renal disease?

A. No. I don't think so.

Q. Because of the renal failure, was she more difficult to treat because of the extent of the renal involvement?

A. For who?

Q. For her. In other words, was the --

A. She didn't treat herself.

Q. Of course. Was the medical management of her condition by way of the drugs, was it complicated due to the extent of her renal involvement?

A. I'm looking for your orders.

MR. FRASURE: It's in the first section there. The discharge summary might have it.

Can you help him, Howard?

Q. Let me just do this: Let me ask you, do you have an opinion as to whether or not this patient is at increased risk in the future for the development of osteonecrosis?

A. Anybody placed on steroids, I guess, is at some increased risk.

Q. Is she at -- again, not knowing the

full extent of what her initial treatment was -- but is she at increased risk over a patient who has a diagnosis of Wegener's granulomatosis before they have fulminant kidney failure?

A. No.

Q. You're not a rheumatologist, are you?

A. No, sir.

Q. Are you familiar with the impact of corticosteroids as it relates to the progression of osteonecrosis and avascular necrosis?

A. Yes.

Q. And how frequently patients develop avascular necrosis secondary to corticosteroid treatment?

A. It's a common complication.

Q. Do you know, from a statistical standpoint, how frequently patients that have corticosteroids of the dosage that she had early on, how frequently they go on to develop osteonecrosis and avascular necrosis?

A. Depends on what you give them in conjunction with that.

Q. There is going to be an opinion at the time of the trial that she is at increased risk of developing osteonecrosis, and more likely than

not will have avascular necrosis of at least three major bones at some time during her lifetime.

Are you, based upon your training and experience, able to opine one way or another on that issue?

A. I won't render any opinion on that. If it's -- I don't -- I would not be surprised.

Q. Okay.

A. However, we saved this lady's life.

MR. FRASURE: Let me just add for the record, Dr. Zarconi has not been deposed, so I think he reserves the right to see what Dr. Zarconi says on that issue.

Q. Doctor, you said that we saved her life. The people at Akron City saved her life when she presented?

A. Yes. I didn't, obviously, but I mean -- yes.

Q. Right. Now, in your report you indicate that Vickie Miglore indicated in her deposition that the doctor was concerned about her condition, wanted to see her again and wanted to do some more testing.

A. Yes, sir.

Q. There's no indication from her testimony as to what that additional testing was to be, was there?
A. Not to my knowledge.
Q. And, in fact, in the testimony of -- or in the records, there's no indication that the doctor, other than in six weeks checking the liver enzymes, wanted to do any other additional testing; true?
MR. FRASURE: From the record you're asking him?
MR. MISHKIND: Right.
A. To my knowledge, not from the record.
Q. In the record, the doctor indicates he wanted to check the liver enzymes in six weeks; true, or did you not see that?
A. I want to review it. I think that's true.
Q. Okay.
A. But that's what I recollect. It does say recheck liver enzymes.
Q. It doesn't say anything about recheck the urine; correct?
A. Correct.
Q. Certainly, he had a plan noted to

check the blood, but the records don't reflect that he had a plan to check the urine; true?

A. He had a plan -- he said recheck -- he said recheck six weeks liver enzymes. That's all I can say.

Q. It doesn't say recheck urine six weeks?

A. It doesn't say anything.

Q. You make a statement -- I'm just curious as to why you have it in your report -- while the patient saw other physicians in September and October of that year, she did not see any primary care physicians including Dr. Cola. Of what import is that statement?

A. On 8-27-97, with this dramatic of complaints, she never followed up on it. I find that astonishiing.

Q. She should have been seen by Dr. Cola, no question about it; correct?

A. No. No. If she wasn't happy with him, she should have seen somebody. She should have seen somebody.

Q. I'm saying on August 27th, when she called that office, she called conveying symptoms to her doctor, Dr. Cola; true?

A. Yes.
Q. Is there any indication on August 27, 1997 that she was just calling to convey symptoms and had no desire of seeing Dr. Cola or having him treat her?
A. There is no opinion either way.
Q. Well, doctor, wouldn't you find it as remarkable if a patient called to tell the doctor here are the symptoms that I have and the receptionist notes, wants to know what this is, yet she has no intention of seeing the doctor for those symptoms, wouldn't you find that even more remarkable?
A. What, that she has no intentions of seeing him?
Q. If she called on August 27 and just gave him those symptoms but didn't have any intention or desire to see him on August 27.
A. Obviously, by that note, she had a desire to continue to see him.
Q. That's all I'm talking about, is on August 27th.
A. Yeah. There's nothing that I would think is otherwise.
Q. Again, going back, it says while the

patient saw these physicians in October, she did not see any primary care physician, including Dr. Cola, and you said with those symptoms on August 27 -- I can't remember what the word you used was -- but some very explicit demonstration that there was a huge list of signs and symptoms that needed to be evaluated; true?

MR. FRASURE: Objection.

A. That I would have. I don't know the patient. I don't have the ten-year history when she presented these symptoms to me. I would have seen her.

Q. So explain to me what the additional import there is of that sentence in your report, while the patient saw other physicians in September and October, she did not see any primary care physicians, including Dr. Cola?

A. The patient saw other physicians in September and October of that year. She did not see any primary care physicians, including Dr. Cola.

MR. FRASURE: He's asking what do you mean by that.

Q. Yes. Are you blaming the patient?

A. No, I don't blame patients.

Q. You don't --
A. See, I see this -- she's an adult. I'm not blaming her. But it's a two-way street.
Q. Okay.
A. It's a two-way street. If I come to you, if there's something that concerns me, or -- and I don't get that message across to you, I have an obligation to make you realize what I'm thinking.
Q. There's a responsibility?
A. There is a responsibility, okay. Now, she saw two other physicians, and from the way I read those records, it was apparent to me that -- I forgot which one of them; one of them said she's going to see Dr. Spoljaric in a couple of weeks.
Q. You're talking about Dr. Torok's note on September 14th or 11th?
A. Whenever it was.
Q. Okay.
A. So, again, if Torok -- just having been in this awhile, if Torok knew that, and he transmitted anything, he would be transmitting it to Spoljaric. So Cola wouldn't have necessarily gotten that information. I don't know. So

there's a lapse here.

Q. You don't know, do you, what efforts Vickie Miglore made to get in to see Dr. Cola after she made this telephone call on August 27, 1997, other than what you see in these notes; correct?

A. Other than what I see in the deposition.

Q. You have heard Vickie testify that she called on three or four occasions and didn't return telephone calls from the doctor; correct?

A. I heard her story, yes, or read her story.

Q. Are you discrediting or are you discounting those statements?

A. No, but I'd like to see who she talked to, and I would like to hear that person. Having been in this situation more than once with patients, the stories sometimes get distorted, as you well know, on both sides.

Q. Well, certainly if this patient needed followup, whether it was by the primary care doctor or whether it was a referral to someone else and needed antibiotics for a presumed infection, whether that was accurate or not,

leaving a message on a machine and not making any further effort to reach the patient, that would not be reasonable and prudent, would it?

A. One message on a machine?

Q. Correct.

A. In my opinion, no.

Q. Now, there's a note on September 1, no answer. You don't know who made that call, do you?

A. No, sir.

Q. Now, we know that Vickie called on September 4 needing a referral to Dr. Torok?

A. Yes.

Q. And there's no indication on September 4 that anyone notified Vickie at that point, oh, by the way, we've got a prescription for you, we want to send you to a referral, we want to schedule you for something, is there?

A. I don't see where that would necessarily have come up.

Q. There's no indication that there was any followup on the message from August 27th in the context of here is a patient calling in to the doctor's office, for whatever reason she wants to go see Dr. Torok, at that particular

point, would you agree that Dr. Cola's office had an opportunity to convey to Vickie we've got some unfinished business in terms of your test? Even if she ignored the telephone call, the message, for some reason there was a message left and she said I'm not going to call him back, I'm not going to do anything, I'm going to go see another doctor, and that was the point she decided to do anything, there was an opportunity on September 4 for Dr. Cola's office to communicate what was noted in the records in terms of referral to a neurologist, prescribing antibiotics, and they knew at that time that it had not taken place; true?

MR. FRASURE: Objection. Compound question. Go ahead.

A. She calls in for a referral to Dr. Torok, I don't know who she got on the phone. Whoever she got on the phone, I don't know if that person would have necessarily reviewed all the records. Based on what I see, I don't know if there's a problem list in the front of his chart that I'm not privy to. I don't know if there's a sticky that says on the front of his chart. I don't know any of that stuff. So I

can't very well say that that's -- that that opportunity would have been as physically present as you alluded to it.

Q. Chart's available, is it not? Her chart was available in the office?

A. I don't know where he keeps his charts.

Q. Have you seen the original chart to see that?

A. No, sir.

Q. Have you seen a copy of the chart to see the note made on September 4?

A. I've seen this.

Q. Okay.

A. My copy.

Q. All right. Is there any indication, even in October of 97, that Dr. Cola, when he faxed results to Dr. Shirach's office, that he faxed to Dr. Shirach the blood, the unexplained hematuria?

A. Shirach is the GI doctor?

Q. Correct.

A. There would have been no reason for him to do so.

Q. As of October 24, 1997, can we

agree -- as of October 24, 1997, can we agree that, based upon everything that you have reviewed, the existence of the unexplained hematuria had never been communicated by Dr. Cola to Vickie Miglore; true?

A. He stated, I thought, in the depositions and everything, they stated they wanted to see her.

Q. My question is as of October 24, had she been notified of the unexplained hematuria?

A. Based on his record, I don't see where that was done.

Q. And can we also agree that Dr. Torok's office was not advised of unexplained hematuria, whether he --

A. I don't know that.

Q. Can we agree that you see no evidence in this case that as of October 24, 1997 Dr. Shirach's office was advised of the unexplained hematuria?

A. Okay. SWOP.

MR. FRASURE: Spoke with on phone.

A. Needs results or referral faxed. Test results faxed. That's all I see.

Q. But you have reviewed the case and

you're testifying as an expert in this matter. Tell me, based upon the information from Dr. Shirach's office, what test results were provided to Dr. Shirach.

A. That was a different question. Where is that data? Shirach's -- that's a different question. Where is Shirach's?

MR. FRASURE: It's in Dr. Spoljaric's chart.

MR. FRASURE: It's got a lab sheet on the front.

A. Okay. Now you want me to go where now?

Q. This was all in the context, doctor, of can we agree that there is no evidence, even as of October 24, 1997, that Dr. Cola's office, now having known that Vickie didn't return, had seen Dr. Torok, had seen Dr. Shirach, is there any indication that Dr. Cola provided Dr. Shirach with an explanation that she had unexplained hematuria?

A. Based on the October 24th, 1997 note by Shirach that I have, there is -- he did not address that issue.

Q. We know that based upon that, and can

we agree that most likely what was faxed over, that what Dr. Shirach is referring to, is the blood work that had been done at Barberton Citizen's Hospital; true?

A. The liver.

Q. Right.

A. I would assume that's true.

Q. Okay.

A. But I don't know that for a fact.

Q. But that certainly is a reasonable conclusion to make based upon reading that note; is it not?

A. Correct.

Q. So we have Dr. Cola aware that, at least according to his note, that the patient had never been talked to about referral to a neurologist?

A. Neurologist?

Q. Neurologist, yes.

A. Okay.

Q. Was a referral to a neurologist what should have occurred at that time?

A. On what day?

Q. August 27th.

A. I can't say that. I can't say that.

Q. All right. I'm sorry.
A. I can't say that.
Q. Why is that?
A. Why is that that I can't say that?
Q. Yes.
A. Because I am not aware of how comfortable Dr. Cola felt with these symptoms. I'm not aware of how comfortable he felt with the previous ten years of this patient, how well he knew her. There is a lot that goes in there, and, again, sometimes you read between the lines on these patients. Remember, his notes are handwritten. And, I mean, that's not as fast and you don't include as much as when you dictate.
Q. Doctor, having said that, we know that the referral to the neurologist had not taken place, we know that at least as of October 24, 1997, Vickie had not been notified, nor had two other doctors that had seen her, been notified of unexplained hematuria; correct?
A. From the notes that were in his charts, you're right.
Q. And from all of the evidence that you have reviewed in this case, my statement is accurate; correct?

A. I guess where I'm having a problem is I don't know if I would have told this patient she had blood in her urine over the phone. I would have not.

Q. If the patient didn't return the telephone call, you would be concerned about the blood in the urine such that you would want to make sure that she was notified of it in some way; correct?

A. I would want to bring her in and tell her that she had blood in the urine, yes, sir.

Q. If she didn't return the call, then you send out a postcard to notify them to schedule an appointment?

A. I would have probably called, had my girls call, a couple times. That would have been clearly documented in my charts.

Q. Would you have stopped making calls at that point, or would you have sent out a card?

A. I think we do send out a card.

Q. That would have been reasonable to do; correct?

A. I think we do, yes.

Q. Now, the standard of care in this case required Dr. Cola to repeat the test on the urine

to see if hematuria was still present; correct?

MR. FRASURE: We've been over that four times now.

A. I believe it should have been followed up.

Q. Now, when you say in your report it's not clear that the test would have shown hematuria because it -- she had no protein in her urine, we've already indicated that the absence of protein doesn't mean that a repeat urinalysis would not have shown hematuria; correct?

A. A repeat urinalysis in the absence of proteinuria may or may not have shown hematuria.

Q. But it should have been done to see what the results were, no question about that; correct?

A. I think you had to follow up on it, yes.

Q. Now, if hematuria had been present and there had been a urinalysis done that showed the dysmorphic change, the red blood cells --

A. Microscopic you said?

Q. Right, microscopic. -- then you would more likely than not need an IVP to evaluate the lower urinary tract; correct?

MR. FRASURE: There's a couple negatives in there; you would not more likely than not.

Q. If you had a microscopic urinalysis that showed red blood cell casts, morphologic changes consistent with renal involvement, the standard of care would not have been to do an IVP; true?

A. If that case scenario came up, true.

Q. When you talk in your report about referring to a urologist, and they would have ordered an IVP, you're presuming that the hematuria, having been checked out on microscopic exam, would not have shown any evidence suggestive of renal involvement; true?

A. No. There's two things you're asking here. One is what's the standard of care that I've come to see in 12 years here or eleven years, however long I've been here, and what should be done.

Q. Are you saying those are two different things?

A. No. I'm saying that not everybody will pick up on red cell casts, technical difficulties, training, whatever you want to

say. They will all pick up on a dipstick positive urine, okay. In my experience, a lot of the hematuria that I see, okay, has been referred to the urologist first and then comes to me.

Q. Okay.

A. The referral pattern -- this is just what I'm seeing here, okay. I'm not telling you whether it's right or wrong. I'm just saying with most of the primary care physicians that I have in this community, the referral on pure hematuria will go urology, then nephrology.

Q. Let's assume that that had taken place.

A. That had taken place.

Q. Let's assume it went urology, nephrology. How long does it take to schedule an IVP?

A. Wait a minute. Let's say that had taken place. In what time frame? Obviously there was not too much concern here.

Q. Why do you say that?

A. The hematuria was present, he was going to check it, presumably, at a later date.

Q. Let me stop you. When you say there wasn't too much concern, on whose part?

A. They were following it up in four to six weeks, the doctor.

Q. Where does it say that in the records that he was planning on following up the hematuria in four to six weeks?

A. I assume he's going to see it the next time she comes in in four to six weeks when she gets her lab work done, and he wants to see her back, and it was presumably -- she wanted to talk to him. He said he'd see her.

Q. When she demanded to talk to him, you believe that he said he would see her?

A. Oh, I think he would see her.

Q. When?

A. She wanted to come in earlier.

Q. Was she given an appointment?

A. Did she make one?

Q. Was she given an appointment? Is there any indication in the record she was offered an appointment and did not keep the appointment?

A. There was no evidence in the record that said she wouldn't be seen.

Q. Doctor, it sounds like you're giving the doctor the benefit of the doubt.

MR. FRASURE: You're arguing the case to the jury, Howard.

A. I'm not giving the benefit of the doubt to the doctor, okay. All I'm saying is I don't see that he fell below a standard of care.

Q. If he had referred her to a urologist, can we agree that, more likely than not, the IVP would have been normal in this case?

A. Retrospectively?

Q. Yes, doctor, because you're looking at the case -- there wasn't a referral to a urologist, was there?

A. Right.

Q. There wasn't further followup on the urine, was there?

MR. FRASURE: We've been over all that.

Q. Was there?

A. No.

Q. So then we obviously have to say retrospectively because we didn't have the benefit of that; true?

A. Yes.

Q. That's a yes?

A. Yes.

Q. Had she been seen by a urologist, can we agree that more likely than not the IVP would have been normal?

A. I don't know.

Q. You don't know, okay. Now, you indicated in your report that Mr. Frasure asked you what medical treatment would have been given if a diagnosis of Wegener's had been made as early as September or October, and she would have needed the same medication to treat the systemic involvement caused by the Wegener's granulomatosis. Is that your opinion?

A. If the diagnosis was made in September or October?

Q. Yes.

A. You're asking me would she have received the same medications? Yes. The dosages may have been different because of the renal manifestations.

Q. And in September and October, you're not going to tell the jury that, had she had a diagnosis, that she would have suffered renal failure anyway, are you?

A. I can't say that either way. I don't know.

Q. All you will acknowledge and concede is that the earlier you diagnose Wegener's granulomatosis, the better it is from the standpoint of prognosis for the patient; true?

A. Salvage.

Q. Well, we know that patients lose, if they're not diagnosed within the first year or so --

A. Right. I thought you referred to -- I was reading into it how much renal function would she now have.

Q. She would have more renal function had it been diagnosed, assuming it was diagnosable, back in September or October or November of 97; true?

A. Assuming it was present then.

Q. And I understand your opinion is it wasn't, but assuming it was --

A. I didn't say it wasn't. I'm saying I don't know.

Q. Just to wrap things up, you don't know whether she had it or not in September or October or November or December of 97; true?

A. I don't know if she had it then or not.

Q. But if it was there and it was diagnosed, you would agree that she would have experienced less renal dysfunction than what she experienced with the diagnosis in March or April of 98; true?

A. She may have.

Q. More likely than not, she would have experienced less; true?

A. If the disease is caught early and treated early, she would have more renal function.

Q. Is she, as Dr. Zarconi has indicated in his report, is she at increased risk for further loss of renal function in the future as a consequence of the extent of the injury that she sustained to her kidneys?

A. I believe that's true.

Q. And is she at increased risk of requiring further kidney dialysis and transplantation then if her glomerulonephritis had been diagnosed before she went into end stage renal failure?

A. She's not end stage.

Q. Didn't she go into end stage?

A. She went into acute renal failure.

End stage is end stage.

Q. In other words, the fact that she came off dialysis, by definition, she --

A. Is not end stage.

Q. Again, going back to my statement, would you agree that she is at increased risk of going into end stage renal failure as a consequence of the -- let me read you the exact words. Strike that.

The fact that she presented with advanced renal failure in 1998, would you agree that, as a consequence of that, she is at increased risk of going into end stage renal failure and requiring dialysis and transplantation then if she had been diagnosed with glomerulonephritis and had not progressed to permanent kidney failure?

A. If that could have been found -- what you're asking is if the disease in the kidney was minimal and you treated it then, presuming that you made the diagnosis of Wegener's, that you could have made it, is her prognosis -- is she less likely to enter end stage than if she was presenting with crescentic glomerulonephritis oliguric on dialysis?

Q. Yes.
A. Yes.
Q. Would you agree that, given her current condition with 30 to 34 percent creatinine clearance, that, and given the extent of her renal disease, that she has lost essentially 50 to 65 percent of her normal renal function?
A. How old is she now?
Q. 50.
A. I'll give you 40, 50, yes, she lost.
Q. Is she, because of her current condition, irrespective of whether she has a flare-up in her Wegener's, is she at increased risk of renal failure over someone else of her same age without this much loss of renal function?
A. Correct.
Q. What is it about this much loss of renal function at her age of 50 that makes her a greater risk than someone with no renal failure?
MR. FRASURE: Objection. I think the comparison should be versus if an earlier diagnosis had been made in the fall.
MR. MISHKIND: You can put it to him

that way at trial.

Q. My question is: Without flare-up of the Wegener's, we know she has roughly 50 or so percent loss of renal function.

A. She has 34 cc's a minute, per minute.

Q. My question, where we were going with this a moment ago was, I want you to explain to me why she is at increased risk of suffering further renal dysfunction given her current status over someone of her age that doesn't have this degree of dysfunction.

MR. FRASURE: No kidney damage, is that what you're saying?

MR. MISHKIND: Right.

A. Why is she at an increased risk? That's a great question. We get a Nobel prize if we figure it out. By comparing data, that is true. If you have suffered renal insufficiency and insult to the kidneys, there is a natural progression of chronic renal insufficiency toward end stage, even if you have totally arrested the disease, okay.

Q. I'm asking you to assume that we totally arrested the disease, okay.

A. Any disease, right.

Q. Totally arrested Wegener's granulomatosis. I'm asking you to explain, from a physiological standpoint, as she ages, why is she at increased risk of going into end stage renal failure and requiring dialysis or transplantation?

A. There's many theories on that as to why that happens; the hyperfiltration theory. The pathophysiology about that has not been worked out to my satisfaction in a concrete fashion where it's universally accepted.

What is universally accepted is she is more at risk, and there is a natural deterioration, once you have renal damage, toward progression of the disease, progression to end stage, even though the initial insult is gone.

Q. Can you tell me, or do you have an opinion to a reasonable degree of medical certainty, as to whether her current condition, as you understand it, will have an impact on her life expectancy?

MR. FRASURE: Let me just interpose an objection. I think the test is reasonable degree of medical probability, but go ahead.

A. I'm sorry. Now I don't understand.

MR. MISHKIND: Let me ask the questions.

Q. Do you have an opinion, based upon her current condition, whether or not her disability will have an impact on her life expectancy?

A. Do I know it will have an impact?

Q. Not to a certainty, but is it more likely than not, given the state of her disease, that she will have a reduced life expectancy?

A. Based on the renal disease?

Q. Yes.

A. It's possible. It's possible.

Q. Can you tell me whether -- when you say possible, what do you mean by that?

A. It's possible. I mean, it's possible that she may have a diminished life expectancy based on the renal manifestations of Wegener's.

Q. Why is that?

A. Because it's damaged.

Q. Based upon your training and experience and reading the literature, do patients that have this degree of renal dysfunction normally live what is considered to be a normal life expectancy, or do more of them succumb to further problems secondary to the

dysfunction that they have?

A. They may or may not have problems from their renal disease as time goes on, okay. When you get down to the individual case, I don't know what the status of her heart is, I don't know what the status of other organs in this patient are. She is 50 years old. The assumption, if you want to make any assumptions, she has coronary artery disease. I've never laid eyes on this lady, but from living here in this country, from what I have seen, she's on the heavy side, 50 years old, she has coronary artery disease as a given. Obviously, she has renal insufficiency. You're asking me if, more likely than not, is it going to be the renal disease that does her in. That's what I understand you're asking me, and I'm saying I don't know.

Q. Do you have an opinion, to a reasonable degree of medical certainty, as to whether it's likely that she will have a flare-up in her Wegener's granulomatosis in the future?

A. There's a good possibility she will have a flare-up.

Q. When you state a good possibility, the law requires that we speak in terms of

probability. Is it more likely than not, based upon your knowledge of this disease process, that she will have a flare-up at some time in the future?

A. Ballpark figures, 50 percent.

Q. Is that based upon your reading in the literature?

A. Right, yes.

Q. How many Wegener's patients do you treat?

MR. FRASURE: Has he ever treated or currently?

Q. How many patients do you currently have in your practice that you have treated?

A. I might have about four or five of them right now active.

Q. How many have you treated all told?

A. Since I started, probably about 15, total.

MR. FRASURE: I'm sorry?

THE WITNESS: About 15.

MR. FRASURE: 15 or 50?

THE WITNESS: 15.

Q. And have those patients been ones that have been referred to you after Wegener's was

diagnosed and they had experienced some renal disease?

A. Well, obviously, most of those patients have been -- have been involved with renal disease based on the Wegener's. Some have been referred because they carry the diagnosis of Wegener's and they move to the area. I don't know if that's what you're asking, but that's true.

Q. Have you ever studied those patients to determine whether their Wegener's -- when their symptoms first materialized and when they developed the glomerulonephritis?

A. The ones that I have been involved in diagnosis have been in the hospital in a similar situation, the way Zarconi was introduced to this patient.

Q. But as to what had gone on beforehand, whether or not suspicion of Wegener's could have and should have been made in those patients, you don't know how soon before they presented that they had signs and symptoms suggestive of some type of vasculitis, do you?

A. When they present, they had signs and symptoms before they hit the hospital door. I

wasn't very critical of the exact duration, and I obviously didn't study in this detail. I'm having a hard time with a lot of nonspecific complaints being attributed to a disease that later turns out to be a very rare, specific disease.

Q. It's an uncommon disease; correct?

A. Right.

Q. That doesn't mean that there aren't certain signs and symptoms that are suggestive of vasculitis; correct?

A. Vasculitis is a very hard -- almost anything and everything can present -- be symptoms of a vasculitis.

Q. And even though it's an uncommon disease, there are inflammatory changes that this patient had, arthritis inflammatory changes, that in retrospect may have been associated with her Wegener's granulomatosis?

MR. FRASURE: Objection. It's not the test. It may have been.

A. It's possible. It's possible.

Q. And we know that the doctor, Dr. Torok, that saw her in September was concerned about inflammatory changes that were going on in

the patient; correct?
A. He was concerned with arthritis.
Q. Right. And he thought that it might be some type of an inflammatory or arthralgia type of condition; true?
A. He was concerned with -- yes.
Q. But he didn't have the benefit of hematuria at that point; correct?
A. Based on what we see, no.
Q. That would have been helpful, would it not?
A. To Torok?
Q. To whoever is going to work the patient up for the cause of her inflammatory symptoms or her arthritic symptoms to determine whether or not they're secondary to a vasculitis.
A. Torok was an orthopedic surgeon, was he not?
Q. Yes.
A. Orthopedic surgeon may or may not have placed much weight in that urine. A nephrologist obviously would have. A rheumatologist probably would have. That's just the way I look at it.
Q. We know that he wasn't provided that

information to whatever extent it would have led to the next steppingstone, if you will?

A. Correct. Correct. That's in the record.

Q. As Vickie gets older, would you agree that her glomerular filtration rate decreases at about one percent per year?

A. One ml. Actually, about .8, okay. Ballpark, 1 ml per minute per year.

Q. If she has a flare-up in her Wegener's, she will, more likely than not, experience more involvement affecting her kidneys than if she doesn't have a flare-up in her Wegener's; true?

A. I suspect that would be true. More likely, right?

Q. Yes. So the combination of aging on top of an already permanently damaged kidney, if she has a flare-up in her Wegener's, she's at even increased risk of having further renal dysfunction and needing dialysis or transplantation; true?

A. Yes.

Q. That's a yes?

A. Yes.

(Discussion off the record.)
MR. MISHKIND: Mark, on the record, I'm taking this doctor's deposition who was identified to me just a week ago, and I'm entitled to take a discovery deposition of him, so whatever time it takes me, I will take.
Q. We talked earlier about C-ANCA and whether -- I think it was in the context of whether it would or would not have been ordered.
A. Right.
Q. Do you remember that?
A. Right.
Q. Is a C-ANCA a very specific antibody or test for Wegener's granulomatosis?
A. How do you mean specific?
Q. When one is looking at laboratory studies that are done that lead one to diagnose Wegener's, is C-ANCA and P-ANCA specific laboratory findings that have a high correlation to Wegener's, if positive?
A. The sensitivity or specificity of those tests are such that yes; however, it depends on the prevalence of the disease.
Q. Explain to me.
A. The prevalence of a disease, if you

look at a C-ANCA and P-ANCA, and we screen everybody that walks past that bridge, you're going to pick up more false positives than true Wegener's.

Q. Okay.

A. However, if you and I do a detailed history and physical and we get a subset of patients that you and I agree clinically are more likely to have that diagnosis, meaning the prevalence goes way up in that population, assuming we're good, yes, they're very helpful. It's not pathognomonic, though.

Q. I'm not suggesting that it is.

A. Okay.

Q. But it is a valuable test to use if one is suspecting Wegener's granulomatosis; true?

A. It's a valuable test in a high prevalence situation, yes.

Q. In order to get to the high prevalence situation, you would have to have a number of signs and symptoms as well as other laboratory tests that would lead you to C-ANCA or the P-ANCA; true?

A. You clinically have to have a patient that presents with a high index of suspicion of

the disease, yes.

Q. Doctor, let me ask you this first, and it may or may not alleviate some of my other questions. I have a report from you dated October 2nd. I've asked you a lot of questions about, I believe, most areas of your report.

Are there any other opinions concerning standard of care that you intend to offer at the trial of this matter that we have not already discussed?

A. I don't think so.

MR. FRASURE: I have a few that I might ask him, just for clarification.

MR. MISHKIND: Well, I'm here --

MR. FRASURE: Let me object as the fellow from Cleveland has done on two of my depositions. That's an improper question. That's what I was always told by you, so I'll object.

I have a couple areas I think he's covered, but I just want to be sure, that I'll be happy to mention.

MR. MISHKIND: If they're not contained in the report.

MR. FRASURE: Dr. Hadley

Morgenstern-Clarren testified to things that were not in his report.

Q. Do you intend to offer any criticisms with regard to any of the care provided by Dr. Spoljaric?

MR. FRASURE: We've been over that. He said no.

A. No, sir.

Q. Dr. Spoljaric had an elevated sed rate; correct?

A. Yes, I believe he did.

Q. An elevation in sed rate is certainly something that you would be concerned about in a patient that had hematuria that is kidney related in origin; true?

A. I think that's nonspecific.

Q. It's nonspecific, but you don't ignore it, do you?

A. I didn't say I'd ignore it. I just don't think it's very helpful.

Q. In any event, you have no criticism of Dr. Spoljaric's care based upon your --

A. Do not. I do not.

Q. And you don't believe anything that he did caused or contributed to the delay in the

diagnosis of Wegener's granulomatosis?

MR. FRASURE: Objection to the term delay. That assumes that there is.

Q. Do you?

A. That he caused a delay?

Q. Exactly.

A. I don't think there was a delay.

Q. So then, in other words, your testimony will be at trial, if asked, that Dr. Spoljaric was not negligent, nor did anything that he did or failed to do caused or contributed to any delay in the diagnosis; true?

MR. FRASURE: He said he didn't think there was a delay.

A. I don't think there was a delay.

Q. So my statement is correct; correct?

A. Say your statement again.

Q. You don't believe he was negligent?

A. I don't believe he was negligent.

Q. You don't believe anything he did led to a timing issue with regard to the Wegener's not being diagnosed sooner; true?

A. I don't think he did anything that delayed the diagnosis.

Q. Okay, that's fine. And we can

certainly agree that, had Dr. Cola, for whatever reason, followed up on lab work and we had diagnosed renal involvement in 1997, that you don't know whether that would or would not have led to the diagnosis of Wegener's back in 1997; true?

MR. FRASURE: Objection.

A. I don't know if it was present.

Q. Right. And we don't have the benefit of those tests having been done. But, had they been done, you can't say that, even with those tests being done, and assuming that they were positive as you, Mr. Mishkind, are suggesting, I can't rule out that Wegener's wasn't there, and I can't rule out that it wouldn't have led to an earlier diagnosis; true?

A. I can't say either way. True.

Q. Now, as you understand it, and has been asked of you by Mr. Frasure, and as you described in the report, are there any other areas that you intend to cover with regard to the standard of care or proximate cause in this case other than what we've talked about?

A. Standard of care, proximate cause, proximate cause meaning what?

Q. What difference it would have made in what injuries or damages were caused. Have we covered all of your opinions?

MR. FRASURE: I object to the question since I'm willing to offer a few things that I will be asking him at trial.

MR. MISHKIND: Mr. Frasure, if you want to go ahead and do that, I'm not suggesting, because I think I have covered everything, I've given him an opportunity to tell me rather than having you, unlike Dr. Hadley Morganstern-Clarren, who indicated to you what he was doing, I'm not going to be sandbagged by opinions if the doctor is not aware or -- there's no other opinions that you have been asked to provide and no other opinions other than what we've exhaustively covered, I want to know that.

Q. Have we covered everything that you're aware of that you have been asked to address that was covered in the report and that you have expressed in this case?

A. Concerning Cola and Spoljaric, yes.

Q. And concerning Vickie Miglore's Wegener's granulomatosis.

A. We didn't get into the City Hospital

records.

Q. Other than the actual treatment, do you have any problems with how she was handled once she got to Akron City Hospital?

A. No.

Q. Other than that, have we covered all of the opinions that you intend to offer at the trial?

A. That I can think of right now, yes.

Q. Okay.

A. Yes.

Q. All right.

MR. FRASURE: Let me go on the record for a couple things. Since Dr. Zizic testified -- I think it was not actually even in his report -- last week, but he thinks the patient could have gotten by with methotrexate with an earlier diagnosis versus cytoxan. I was planning to ask doctor -- I was going to ask Dr. Schwarze at trial if you agreed with that opinion by Dr. Zizic.

THE WITNESS: No, sir.

MR. FRASURE: I was also going to ask him at trial, would the standard of care, even if what Mr. Mishkind is suggesting, would the

standard of care have resulted likely in a diagnosis of Wegener's in the fall of 97?

THE WITNESS: My opinion, no.

MR. MISHKIND: I'm going to move to strike, obviously, in discovery deposition. I'll take it up with the Court. But the way that this has come down, Mark, it's absolutely -- it's beyond absurd.

MR. FRASURE: What does the timing of his identification have to do with whether or not I can say to you he's going to opine on these two extra areas that aren't in his report when your doctors did the same thing?

MR. MISHKIND: That's not the issue I'm troubled by.

Q. Have you seen Dr. Zizic's testimony?

MR. FRASURE: We don't even have it yet.

A. No. I just saw his letter.

Q. You haven't seen his deposition?

A. No.

Q. Are there circumstances where methotrexate is or is not the treatment of choice for Wegener's granulomatosis?

A. The treatment of choice, in my

opinion, is steroids and cytoxan.

Q. Does methotrexate have a lower toxic effect and thus create a lower osteonecrosis potential?

A. I don't know if I would have used it because it's a hepatotoxin, and this patient has chronically elevated liver enzymes. It wouldn't have been my first choice.

Q. Okay.

A. It's an alternative that I know exists, but I have not used that.

Q. Do you know Dr. Zizic?

A. No.

Q. Do you know him by reputation at all?

A. No, sir.

Q. Now, have we covered the opinions that you hold in this case and that you intend to testify to at the trial of this matter? It's a simple yes or no, to your knowledge.

A. To my knowledge, yes.

MR. MISHKIND: Thank you doctor. I have no further questions.

(Deposition concluded at 3:08 o'clock p.m.)

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AFFIDAVIT

I have read the foregoing transcript from page 1 through 152 and note the following corrections:

| PAGE | LINE | REQUESTED CHANGE |
|---|---|---|

_____

KARL D. SCHWARZE, M.D.

Subscribed and sworn to before me this _____ day of _____, 2000.

_____

Notary Public

My commission expires _____.

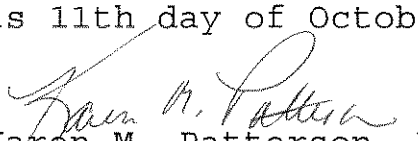
CERTIFICATE

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 KARL D. SCHWARZE, 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 relative or attorney for either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 11th day of October 2000.



Karen M. Patterson, Notary Public
Within and for the State of Ohio

My commission expires October 7, 2004.