

1                   IN THE COURT OF COMMON PLEAS  
2                   OF SUMMIT COUNTY, OHIO

3                   - - - - -

4       VICKIE MIGLORE, et al.,  
5                   Plaintiffs,

6                   vs.   Case No.

7       DAVID COLA, D.O., et  
8       al.,

99 CV 030973

9                   Defendants.

10                  - - - - -

11                 DEPOSITION OF KARL D. SCHWARZE, M.D.

12                 Tuesday, October 10, 2000

13                  - - - - -

14                 Deposition of KARL D. SCHWARZE, M.D.,  
15       a witness herein, called by the Plaintiffs for  
16       examination under the statute, taken before me,  
17       Karen M. Patterson, a Registered Merit Reporter  
18       and Notary Public in and for the State of Ohio,  
19       pursuant to notice and stipulations of counsel,  
20       at the offices of Karl D. Schwarze, M.D., 224  
21       West Exchange Street, Akron, Ohio, on the day and  
22       date set forth above, at 11:40 o'clock a.m.

23                  - - - - -

24

25

1 APPEARANCES:

2 On behalf of the Plaintiffs:

3 Becker & Mishkind Co., L.P.A., by

4 HOWARD D. MISHKIND, ESQ.

5 1660 West 2nd Street

6 Suite 660 Skylight Office Tower

7 Cleveland, Ohio 44113

8 (216) 241-2600

9

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

11 Buckingham, Doolittle & Burroughs, by

12 MARK D. FRASURE, ESQ.

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14 P.O. Box 35548

15 Canton, Ohio 44735

16 800-686-2825

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1           KARL D. SCHWARZE, M.D., of lawful age,  
2   called for examination, as provided by the Ohio  
3   Rules of Civil Procedure, being by me first duly  
4   sworn, as hereinafter certified, deposed and said  
5   as follows:

6           EXAMINATION OF KARL D. SCHWARZE, M.D.

7   BY MR. MISHKIND:

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

10          A.     Karl Schwarze.

11          Q.     You are a physician; is that correct?

12          A.     Yes.

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

18          A.     Next week?

19          Q.     Yes.

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

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

25          A.     Yes.

1           Q.     I've had a chance to review the  
2     contents of your file, and is everything that you  
3     have reviewed in front of you there, doctor?

4           A.     Yes.

5           Q.     And based upon your review, you wrote  
6     a report to Mr. Frasure dated October 2, 2000; is  
7     that correct?

8           A.     Yes.   Whatever the date was on the --

9           Q.     Why don't you get the report in front  
10    of you so you don't have to assume that I'm  
11    stating anything accurate.

12          A.     Okay.   Yes.

13          Q.     And that is the only letter that you  
14    have written --

15          A.     Yes.

16          Q.     -- in this case; true?

17          A.     Yes.

18          Q.     In reviewing the material, it appears  
19    that you were first contacted by Mr. Frasure to  
20    review records sometime towards the end of  
21    September of this year; true?

22          A.     Yes.

23          Q.     Would you in fact refer to the letter  
24    that is in the material from Mr. Frasure, and,  
25    for the record, indicate what the date was that

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

3 What is the date of that letter,  
4 please?

5 A. 21st of September.

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

8 A. Sure.

9 Q. Thank you. And the letter refers to a  
10 phone conversation. I presume that phone  
11 conversation took place on that date of September  
12 21 or close to that?

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

15 Q. Within a day or two of September 21?

16 A. Yes.

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

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

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

1           A.     Recent conversation. I don't remember  
2     the date, but yes.

3           Q.     It certainly wasn't anything beyond  
4     the latter part of September, was it?

5           A.     Correct.

6           Q.     And then after you received this  
7     letter dated September 21, 2000, you reviewed  
8     material which is in front of you; true?

9           A.     Correct.

10          Q.     And in the material, I see that you  
11     have reviewed the Cleveland Clinic records;  
12     true?

13          A.     Correct.

14          Q.     And information from Dr. Gary  
15     Hoffman?

16          A.     Correct.

17          Q.     Is Dr. Hoffman considered an expert in  
18     the area of Wegener's granulomatosis?

19          A.     Yes.

20          Q.     Do you consider Dr. Hoffman to be a  
21     well respected rheumatologist at the Cleveland  
22     Clinic?

23                   MR. FRASURE: Objection. Go ahead.

24          A.     I consider him a rheumatologist at the  
25     Cleveland Clinic.

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

5 A. I have no concerns with Dr. Hoffman.

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

13 MR. FRASURE: Objection. Go ahead.

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

16 Q. So my statement is accurate? Well  
17 respected?

18 A. I respect him, yes.

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

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

1           A.     Recent conversation. I don't remember  
2     the date, but yes.

3           Q.     It certainly wasn't anything beyond  
4     the latter part of September, was it?

5           A.     Correct.

6           Q.     And then after you received this  
7     letter dated September 21, 2000, you reviewed  
8     material which is in front of you; true?

9           A.     Correct.

10          Q.     And in the material, I see that you  
11     have reviewed the Cleveland Clinic records;  
12     true?

13          A.     Correct.

14          Q.     And information from Dr. Harry  
15     Hoffman?

16          A.     Correct.

17          Q.     Is Dr. Hoffman considered an expert in  
18     the area of Wegener's granulomatosis?

19          A.     Yes.

20          Q.     Do you consider Dr. Hoffman to be a  
21     well respected rheumatologist at the Cleveland  
22     Clinic?

23                   MR. FRASURE: Objection. Go ahead.

24          A.     I consider him a rheumatologist at the  
25     Cleveland Clinic.



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

5           A.     I have no concerns with Dr. Hoffman.

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

13               MR. FRASURE: Objection. Go ahead.

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

16          Q.     So my statement is accurate? Well  
17    respected?

18          A.     I respect him, yes.

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

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

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

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

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

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

12 A. Yes.

13 Q. You reviewed his records; true?

14 A. I reviewed his letter, yes.

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

18 A. Correct.

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

22 MR. MISHKIND: Two weeks.

23 MR. FRASURE: Whatever it is.

24 MR. MISHKIND: Yes.

25 MR. FRASURE: Look at his letter,

1 doctor.

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

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

7 MR. MISHKIND: I'm not objecting.

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

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

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

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

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

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

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

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

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

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

4 A. True.

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

7 A. To a doctor, yes, true.

8 Q. Do you know which doctor that was?

9 A. I'd have to look.

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

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

15 Q. Have you read that?

16 A. Yes, I have, sir.

17 Q. When did you read it last?

18 A. Within the week.

19 Q. Go ahead.

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

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

24 A. Correct.

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

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

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

11            A.     Let me review it again.

12            Q.     Go right ahead.

13            A.     Okay.

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

16            A.     Yes.

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

21            A.     I take issue with.

22            Q.     In what respect?

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

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

5           A.     Yes. I assume that was correct.

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

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

13          Q.     Okay.

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

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

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

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

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

1 recall when she came off dialysis.

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

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

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

11 A. I don't believe I said that.

12 Q. Okay.

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

15 Q. And, again, you have --

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

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

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

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

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

10 A. No, sir, I don't.

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

13 A. Yes, sir.

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

16 A. Yes.

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

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

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

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



1 Q. Where are those card pages?

2 A. It's a three-by-five. I don't think I  
3 have it here. I was reading these at home. I  
4 don't think I have it here. Do you want me to  
5 look in my office? It was one card,  
6 three-by-five, on Mrs. Miglore's deposition, just  
7 pages that I thought I might want to review  
8 again, but that was it. But I circled that --  
9 circled the page number in her deposition, too.

10 Q. You don't have that card with you  
11 today?

12 A. I don't believe I do, sir.

13 Q. Is there anything else that you have  
14 reviewed or created in the course of your review  
15 that you don't have with you today other than  
16 this card?

17 A. No. I mean -- no. Notes for, you  
18 know -- I mean, I don't understand what you want  
19 me to answer here. What are you specifically  
20 asking? Do I have a hard copy of notes of an  
21 extended research that I've done on this case?  
22 No, I do not. Is that what you're asking?

23 Q. A moment ago I asked you, when you  
24 read her deposition, whether you made any notes,  
25 and you said that you circled some pages and then

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

3             A.     Correct. I wrote the page numbers.

4             MR. FRASURE: Wrote what?

5             THE WITNESS: The page numbers.

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

12            A.     No, sir.

13            Q.     Okay.

14            A.     The only card was that card.

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

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

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

25            A.     No.

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

3           A.     I review medical texts to date.

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

8           A.     No, sir.

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

11          A.     No, sir.

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

14          A.     No, sir.

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

17          A.     Have I ever lectured?

18          Q.     Yes.

19          A.     Yes.

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

24          A.     Yes.

25          Q.     Which lectures or which topics would

1     those be?

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

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

7           A.     Rapidly progressive  
8     glomerulonephritis.

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

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

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

19          A.     Correct.

20          Q.     Did you keep a copy of that material?

21          A.     No.

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

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

3           Q.     Yes.

4           A.     Yes.

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

11          A.     Okay. Sorry.

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

17          A.     Yes.

18          Q.     When and where?

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

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

24          A.     Correct.

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

1 A. Correct.

2 Q. With regard to any of the lectures  
3 that you have given on glomerulonephritis, have  
4 you disseminated anything in writing to the  
5 audience that you were speaking to?

6 A. Yes.

7 Q. Do you have any of the written  
8 materials that you disseminated?

9 A. I hope I do.

10 Q. Was it just something within the last  
11 year or so?

12 A. Within the last year or two.

13 Q. Is that something that you could  
14 retrieve from your office while we're here?

15 A. If I can, you're welcome.

16 Q. I'm sorry.

17 A. Yes. If I can, it would be here.

18 Q. What I would like to do is complete my  
19 questioning, and then before we adjourn, if you  
20 can see if you can locate it just to determine  
21 whether or not I have any questions for you based  
22 upon that. Okay?

23 A. Okay. It's -- okay.

24 Q. Did you want to say something? Go  
25 ahead.

1           A.     That's all right.

2           Q.     You were going to say something about  
3     the material?

4           A.     It's pretty basic.

5           Q.     Are there any articles or authorities  
6     in the area that you practice in that you deem to  
7     be authoritative as it relates to the diagnosis  
8     and treatment of glomerulonephritis?

9           A.     Rephrase that.

10          Q.     Do you consider any medical texts in  
11     the area of nephrology or neurology to be  
12     authoritative?

13          A.     I guess I have trouble with the term  
14     "authoritative." I don't rely on any one  
15     source. I hold certain books in high regard.  
16     But I don't base a diagnosis based on one text.

17          Q.     Let's talk about the ones that you  
18     hold in high regard. Do you consider those to be  
19     reasonably reliable sources of information?

20          A.     Reliable.

21                   MR. FRASURE: Objection. Go ahead.

22          A.     Reliable. I do.

23          Q.     And which texts would be at the top of  
24     the list that you would deem to be generally  
25     reliable sources of information in your field?

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

3 MR. MISHKIND: Renal disease.

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

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

13 MR. FRASURE: Objection. Go ahead.

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

16 Q. Yes.

17 A. The ones stated.

18 Q. I'm sorry.

19 A. In the books stated.

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

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

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



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

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

5 Q. Prior to preparing your report in this  
6 case?

7 A. Yes.

8 Q. In both of the textbooks?

9 A. Yes.

10 Q. As it relates to Wegener's  
11 granulomatosis?

12 A. Yes.

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

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

18 MR. FRASURE: That goes back 20  
19 years.

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

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

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

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

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

11 A. In the textbooks that I told you.

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

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

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

23 A. No.

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

1 to being contacted by Mr. Frasure?

2 A. Sure.

3 Q. How long have you been practicing  
4 medicine?

5 A. Including residency?

6 Q. Since finishing your residency.

7 A. Since finishing fellowship or just  
8 residency?

9 Q. Fellowship.

10 A. 1988, 1989, right around there.

11 Q. When did you first start reviewing  
12 medical/legal matters?

13 A. I can't remember.

14 Q. Can you give me an estimate?

15 A. Yes. I'm blanking here, but I think  
16 within five years. That's a ballpark figure.

17 Q. Tell me currently how many cases a  
18 year you review.

19 A. I can't say that I have three cases  
20 this year. But prior to that, maybe one or two  
21 previous to that.

22 Q. Do you provide your name or your  
23 ability or your willingness to participate as an  
24 expert through any of the medical/legal service  
25 companies?

1 A. No, sir.

2 Q. Have you ever done that?

3 A. No, sir.

4 Q. Have you ever advertised?

5 A. No, sir. I've always been contacted  
6 through I don't know how, but that's how --

7 Q. How many cases have you reviewed in  
8 the past for the Buckingham, Doolittle law firm?

9 A. Including this?

10 Q. Whatever, if you want to include this  
11 or exclude it.

12 A. One, excluding this.

13 Q. So two in total?

14 A. Two in total.

15 Q. And was that other case at the request  
16 of Mr. Frasure?

17 A. No, sir.

18 Q. Who was it at the request of?

19 A. Mr. Banas.

20 Q. Did you testify in that case?

21 A. No, sir.

22 Q. Has your deposition been taken in that  
23 case?

24 A. No, sir.

25 Q. I take it you reviewed that case

1 longer ago than you reviewed this case?

2 A. Yes.

3 Q. Are you still, to your knowledge,  
4 involved as an expert?

5 A. On that particular case?

6 Q. On that particular case.

7 A. I doubt it.

8 Q. It's been more than a year or so?

9 A. Yes. After I reviewed the case, I  
10 don't think he wanted -- he didn't want -- he  
11 didn't want to use me. He didn't like what I had  
12 to say. That was my impression.

13 Q. So you never wrote a report for him?

14 A. No.

15 Q. Do you know how it is that Mr. Frasure  
16 made contact with you?

17 A. On the phone.

18 Q. Did he tell you how it was that he  
19 obtained your name?

20 MR. FRASURE: Well, we met before.

21 MR. MISHKIND: Please don't testify,  
22 Mark. He'll tell me that. Go ahead.

23 MR. FRASURE: I'm trying to help you.

24 MR. MISHKIND: I really don't need  
25 your help. Thank you.

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

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

6           A.     Correct.

7           Q.     Did Mr. Frasure represent you?

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

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

16          A.     Correct.

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

20          A.     Right. Right.

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

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

1 A. Yes.

2 Q. How many times?

3 MR. FRASURE: Objection.

4 A. That's a public record. I don't know  
5 exactly. I think -- when you ask that question,  
6 do you mean the ones that were just dismissed,  
7 too?

8 Q. I'm asking you where you were served  
9 with papers from a courthouse naming you as a  
10 Defendant, regardless of what the outcome was,  
11 whether it was dismissed, whether you won or lost  
12 the case. I'm just asking all comers in terms of  
13 cases filed against you.

14 MR. FRASURE: Objection. Go ahead.

15 A. I think four. I think four.

16 Q. And, to your knowledge, are any of  
17 those cases still open?

18 A. No, sir.

19 Q. Were all the cases up here in Summit  
20 County?

21 A. No, sir.

22 Q. Where were they?

23 A. Summit County and Houston, Texas.

24 Q. When you were at Baylor?

25 A. Yes, sir.

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

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

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

10 A. Hard to answer that. Indirectly, yes.

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

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

25 Q. There was some type of a nephritis



1 that was encountered?

2 A. Oh, yes.

3 Q. But it was posttransplant or -- was  
4 the nephritis posttransplant?

5 A. Yes.

6 Q. It was a rejection?

7 A. It was transplant rejection is what it  
8 was.

9 Q. Did that case go to trial?

10 MR. FRASURE: Objection.

11 A. I guess no.

12 Q. Your deposition was taken in that  
13 case, though; correct?

14 A. Oh, yes. We went down to trial. I  
15 came down -- when they took my deposition, and  
16 the case was reviewed by many people, okay, it  
17 was apparent that I was not at fault. So they  
18 dropped me, the Plaintiff's attorney, dropped me  
19 and the defense -- it turned out there were more  
20 than one person. I was sued, Baylor was also  
21 sued, and Baylor agreed to drop me if they could  
22 use me as an expert witness. That's what I  
23 understand from the case.

24 So when it went to trial, I was an  
25 expert for that case, so when I -- so I no longer

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

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

12 A. Correct.

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

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

18 Q. Yes.

19 A. Okay.

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

24 A. Yes.

25 Q. But you ultimately didn't testify for

1 the reasons you have already stated; true?

2 A. Yes.

3 Q. What was the name of the case besides  
4 Baylor University as a Defendant? Who was the  
5 Plaintiff, the named Plaintiff?

6 A. When you're at Baylor and the Baylor  
7 faculty, there is no other name. It's Rothman.

8 Q. Roth?

9 A. R-O-T-H-M-A-N, Rothman.

10 Q. Mr. Rothman?

11 A. Yes.

12 Q. What was Mr. Rothman's first name?

13 A. I think it was Robert. I don't know  
14 for sure.

15 Q. Baylor is located in what county in  
16 Texas?

17 A. Harris.

18 Q. The other cases that you have been  
19 named as Defendants --

20 MR. FRASURE: Objection.

21 Q. -- were they up here in Summit  
22 County?

23 A. I believe they're in Summit because  
24 I'm in Summit County, yes.

25 Q. Do any of those cases have anything to

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

3 A. Hard to answer that question.

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

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

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

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

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

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

17              Q.     You blame the patient, though; true?

18                   MR. FRASURE: Objection.

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

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

1           A.     I believe I have.  There may have  
2     been -- I believe I have.

3           Q.     Okay.

4           A.     I think so.

5           Q.     Has Mr. Frasure, other than the  
6     situation where he was covering for Mr. Banas,  
7     has he represented you in the past?

8           A.     To the best of my knowledge, it's  
9     always been Mr. Banas.

10          Q.     To the best of your knowledge, those  
11     cases are gone now?

12          A.     Gone.

13          Q.     Okay.

14          A.     Now, see, you have just jinxed me.

15          Q.     The five years or so that you have  
16     reviewed cases, you said that in the year 2000,  
17     you have reviewed three cases?

18          A.     Yes.

19          Q.     Does that include this case?

20          A.     Yes.

21          Q.     And one or two on average in the  
22     previous years?

23          A.     I think there were one or two total.

24          Q.     Have you ever testified in deposition  
25     as an expert witness up here in Ohio?  In other

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

3 A. As an expert witness?

4 Q. Yes.

5 A. Not yet.

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

9 A. Yes.

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

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

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

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

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

25 MR. FRASURE: He said there were only

1 two more.

2 A. There's only five cases total. I  
3 think one was Plaintiff and one was Defense, but  
4 I don't --

5 Q. I thought you said one or two a year.

6 A. No. No. Total. I said the total.

7 Q. Five cases you have served as an  
8 expert in total?

9 A. I've been asked to review the case in  
10 five cases.

11 Q. Do you know Dr. Cola?

12 A. Not personally.

13 Q. You have hospital privileges at some  
14 of the same hospitals that he has privileges at?

15 A. I believe I do.

16 Q. You know him professionally?

17 A. I think we have shared some patients.

18 Q. He's referred some of his nephrology  
19 patients to you; correct?

20 A. To our group.

21 Q. What about Dr. Zarconi, do you know  
22 Dr. Zarconi?

23 A. Yes.

24 Q. Do you know him more than  
25 professionally?



1 A. Yes.

2 Q. Personal friend of his?

3 A. We're friends.

4 Q. Have you had occasion by circumstance  
5 or otherwise to have talked with Dr. Zarconi  
6 about this case?

7 A. No, sir, I have not.

8 Q. Do you hold Dr. Zarconi in high regard  
9 as a nephrologist in this area?

10 A. He's my competition.

11 Q. And I don't mean to be disrespectful  
12 or funny about it, but he can be your competition  
13 and you may feel that he's an excellent  
14 nephrologist, or he may be your competition and  
15 you have no opinion of him, or you may think that  
16 he's really a very good nephrologist.

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

20 MR. FRASURE: Objection. Go ahead.

21 A. Yes.

22 Q. And what is that?

23 A. I think he's a good friend, fine human  
24 being, and a good nephrologist. I do hold him in  
25 high regard. Equal.

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

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

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

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

20 Q. Okay.

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

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

25 A. I do not recall that.

1           Q.     You may have; you just can't say one  
2     way or another?

3           A.     Right.

4           Q.     What you can say is that Dr. Cola has  
5     made referrals to your practice group. Whether  
6     you were involved or not, that you can't say?

7           A.     I believe that's true.

8           Q.     Have you had occasion to talk to Dr.  
9     Cola at all since you have been involved in this  
10    case?

11          A.     No, sir.

12          Q.     And I take it that that would also  
13    include talking with him about matters unrelated  
14    to this case as well?

15          A.     Haven't talked to him. With the short  
16    time, that's fairly easy to assure.

17          Q.     The CV that Mr. Frasure sent over to  
18    me has a few publications on it.

19                   (Discussion off the record.)

20          Q.     The publications that are referenced  
21    in the CV that Mr. Frasure sent to me, there are  
22    five publications. Is that the extent of the  
23    publishing that you have done?

24          A.     Yes.

25          Q.     Anything submitted for publication?

1 A. Not at this time.

2 Q. Have you submitted anything in the  
3 past for publication that was rejected?

4 A. No.

5 Q. Just to focus me in, tell me what you  
6 understood your assignment to be as it relates to  
7 this case. What were you asked to do?

8 A. Reading Mr. Frasure's letter, it was  
9 my understanding that I was supposed to review  
10 the records that he sent me and give him a call  
11 and discuss them after I had read them.

12 Q. Were you asked to provide standard of  
13 care testimony as it relates to whether Dr. Cola  
14 met or fell below accepted standards of care?

15 A. I was asked to review the record and  
16 discuss the case. That's what I was asked to do.

17 Q. Do you hold opinions that you intend  
18 to offer at the trial as it relates to whether  
19 Dr. Cola did or did not meet the standard of care  
20 for a primary care physician?

21 A. I intend to give an opinion on whether  
22 I think he met the standard of care.

23 Q. And I take it your opinion is that he  
24 did meet the standard of care?

25 A. Correct.

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

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

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

16          A.     Specifically not asked.

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

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

25          Q.     You have not written any subsequent

1 reports expressing any additional opinions?

2 A. No. No.

3 Q. As you sit here right now, are you  
4 critical of any other doctors in terms of the  
5 care or management of Vickie Miglore?

6 A. No.

7 Q. Let's see if we can come to some  
8 agreement on some things and then we'll see what  
9 we can come to some disagreement on. Fair  
10 enough?

11 A. Fair.

12 Q. First, let me ask you to tell me what  
13 you believe caused her glomerulonephritis.

14 A. The one that was biopsied in March?

15 Q. Yes.

16 A. I believe it was rapidly progressive  
17 crescentic glomerulonephritis secondary to  
18 Wegener's.

19 Q. Can we agree that, according to the  
20 information that you have available and the  
21 evidence that has been provided to you that  
22 Vickie did not have any preexisting renal or  
23 kidney disease before the Wegener's  
24 granulomatosis caused the inflammation of the  
25 glomeruli?

1 A. No, I can't go along with that.

2 Q. Why?

3 A. Because I don't know that.

4 Q. Do you have any evidence to say to a  
5 probability that she had renal or kidney disease  
6 prior to the involvement caused by the Wegener's  
7 granulomatosis?

8 A. I feel it is possible.

9 Q. But not probable?

10 A. Can't render an opinion on that. I  
11 just don't know.

12 Q. Can we agree that it's not uncommon to  
13 see normal creatinine and BUN levels in early  
14 stages of glomerulonephritis?

15 A. Define normal.

16 Q. Within normal laboratory parameters.

17 A. Yes.

18 Q. Can we also agree that  
19 glomerulonephritis can be treated on an  
20 outpatient basis as long as the blood pressure  
21 and the creatinine and BUN are normalized or  
22 within normal limits?

23 A. That's a broad, broad statement. I'm  
24 sure you did that purposely. Some can be.

25 Q. Generally speaking, if the BUN and the

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

5 A. I cannot say generally.

6 Q. More often than not.

7 A. Depending on the cause.

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

14 A. Are you saying once the diagnosis is  
15 established?

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

25 MR. FRASURE: You're assuming the



1 diagnosis is made?

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

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

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

20 Q. Yes.

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

1 outpatient.

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

8 MR. FRASURE: Secondary to Wegener's?

9 MR. MISHKIND: Yes.

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

12 Q. Yes.

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

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

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

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

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

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

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

18 Q. So you have made the diagnosis of  
19 glomerulonephritis?

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

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

1           A.     Kidney involvement of what?

2           Q.     Necrotizing glomeruli secondary to  
3     Wegener's.

4           A.     No.   Why would you say that, you have  
5     Wegener's, when you just have disease in the  
6     kidney that is a glomerulonephritis?

7           Q.     I thought the scenario, doctor --  
8     maybe you and I are not talking the same  
9     language -- the crescentic necrotizing  
10    glomerulonephritis that you have characterized as  
11    what would be secondary to Wegener's, I've asked  
12    you if that was the only system involved.

13                First, let me take a tangent off  
14    that.   You can have kidney involvement and no  
15    other involvement secondary to Wegener's; true?

16           A.     No.

17           Q.     You're saying you can't?

18           A.     No.

19           Q.     You have said no to both questions.  
20    What are you telling me, that you have to have  
21    more than one system involved?

22                MR. FRASURE:   If you have Wegener's?

23                MR. MISHKIND:   Yes.

24           A.     How do you make the diagnosis of  
25    Wegener's?   What are we talking about here?   Are

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

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

14 A. Okay.

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

16 A. Okay.

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

20 A. Okay.

21 Q. How do you go about diagnosing  
22 glomerulonephritis?

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

1 biopsy would be needed, pathologic diagnosis.

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

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

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

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

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

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

20 Q. Okay.

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

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

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

4 A. Sometimes.

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

7 A. Correct.

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

11 A. Correct.

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

15 A. Less common.

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

18 A. It's certainly been recorded.

19 Q. It happens?

20 A. Yes.

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

1 A. Rephrase that.

2 Q. Sure. The more common characteristic,  
3 hallmark, if you will, of system involvement is  
4 upper and lower respiratory secondary to  
5 Wegener's granulomatosis; true?

6 A. True.

7 Q. And then other systems are known to be  
8 implicated as well; true?

9 A. True.

10 Q. More common system is upper and lower  
11 respiratory as the first presenting system;  
12 true?

13 A. True.

14 Q. But that doesn't mean that, while it's  
15 less common, that kidney or renal involvement  
16 isn't at times the first presenting system;  
17 true?

18 A. True.

19 Q. And I guess my question now, tying it  
20 all together is: Simply because you have renal  
21 involvement as the first presenting system  
22 shouldn't cause a clinician to say it's not  
23 Wegener's because it's more common to have it in  
24 the upper or the lower respiratory tract; true?

25 A. I think you have to be careful with



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

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

18 A. That would be in retrospect.

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

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

1 diagnosis.

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

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

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

8 A. No.

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

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

20 Q. Okay.

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

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

1           A.     A lot of times time.

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

9           A.     It depends upon what the presentation  
10 is.

11          Q.     Okay.

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

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

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

4 A. I'm sorry.

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

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

13 MR. FRASURE: Wegener's?

14 MR. MISHKIND: Glomerulonephritis.

15 A. Before permanent damage? You said  
16 permanent function.

17 Q. Permanent renal dysfunction has taken  
18 place.

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

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

25 A. You would hopefully have to arrest the

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

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

7 A. You would look at a creatinine  
8 clearance clinically.

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

11 A. More than likely, yes.

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

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

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

23 A. Loaded question. Sometimes yes,  
24 sometimes no.

25 Q. At what level do you take a patient

1 off of dialysis? When they're above ten?

2 A. Correct. Usually.

3 Q. What is your understanding of the  
4 creatinine clearance that Vickie has currently?

5 A. The number?

6 Q. Yes.

7 A. 32, 34, right around there.

8 Q. What is your understanding, based upon  
9 your review in this case, as to what level she  
10 was at when she went on dialysis?

11 A. I don't recall that figure. I don't  
12 know -- I honestly don't know, without reviewing  
13 the records again, whether they got a creatinine  
14 clearance before they started her on dialysis.

15 Q. Why did they start her on dialysis?

16 A. They felt she was uremic.

17 Q. And was she?

18 A. I wasn't there.

19 Q. Well, you have reviewed the records.  
20 Do you see evidence that would suggest a need to  
21 put her on dialysis?

22 A. I would assume that Dr. Zarconi made  
23 the right diagnosis and she was uremic and needed  
24 dialysis. I certainly would go that far.

25 Q. Define for me uremic.

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

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

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

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

15          A.       Yes.

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

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

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

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

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

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

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



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

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

6 A. No.

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

10 A. No.

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

15 A. Generally speaking.

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

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

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

1 A. Controversial.

2 Q. You're not suggesting that you would  
3 see morphological changes --

4 (Interruption.)

5 (Record read.)

6 Q. -- in red blood cells that are  
7 produced from the lower urinary tract, are you?

8 A. You picked right up on the end of  
9 that, okay.

10 Q. I did.

11 A. My understanding of morphologic  
12 changes in the red cells, okay -- this has been  
13 looked at -- my understanding is that first  
14 morphologic or dysmorphic red cells in the urine  
15 were indicative of upper urinary tract disease.

16 Q. Renal?

17 A. Renal.

18 Q. Okay.

19 A. Whereas nice, regular red cells were  
20 more indicative of lower urinary tract.

21 Q. Okay.

22 A. The problem with that is when you  
23 actually do the microscopic analysis, as I have,  
24 okay, on most of the patients I see, nothing is  
25 in black and white. There is a percentage that

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

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

9 A. Yes.

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

13 A. Correct.

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

18 A. Red blood cell casts indicate  
19 glomerular disease.

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

22 A. Yes. This case spans over --

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

1 A. In August.

2 Q. In August.

3 A. That's when you're referring to.

4 Q. Do you know of any others that he  
5 did?

6 A. I'm referring to the August. He's  
7 followed this patient for a long time.

8 Q. The August one is what I'm referring  
9 to. At that time, he did a urine dipstick;  
10 correct?

11 A. Correct.

12 Q. And there was three plus blood;  
13 correct?

14 A. Correct.

15 Q. That three plus blood told whether or  
16 not there were red blood cell casts in the urine;  
17 correct?

18 A. Correct.

19 Q. In order to determine whether or not  
20 there was red blood cell casts in the urine, he  
21 would have had to have done a microscopic  
22 urinalysis; true?

23 A. Correct.

24 Q. If the microscopic urinalysis had been  
25 done and it showed red blood cell casts in it,

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

4 A. If it showed that, yes.

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

10 A. It raises more of a suspicion.

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

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

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

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

1 A. No, I don't go that far.

2 Q. It expands the list of things that you  
3 would think of, would it not?

4 A. Gross?

5 Q. Yes.

6 A. I don't know if I'll go that far.

7 Q. It would include trauma, would it  
8 not?

9 A. Microscopic can, too.

10 Q. In any event, if you have three plus  
11 blood in the urine, you would agree that that is  
12 something that needs to be investigated; true?

13 A. Followed up.

14 Q. And followup on three plus blood would  
15 include microscopic urinalysis; true?

16 A. I don't know if it has to.

17 Q. Certainly that would be a reasonable  
18 and prudent way to investigate three plus blood  
19 in a urine dipstick; true?

20 A. Certainly it would be reasonable.

21 Q. And if a reasonable and prudent  
22 physician does follow up and does a microscopic  
23 urinalysis and there are red blood cell casts,  
24 then one has to think in terms of glomerular  
25 versus lower urinary tract involvement; true?

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

3 MR. MISHKIND: Just a general medical  
4 standpoint.

5 MR. FRASURE: Okay.

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

11 A. I would hope.

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

14 A. Thanks.

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

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

21 Q. Sure. If you know what it is.

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

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

1 differentiates between glomerular and  
2 extraglomerular disease.

3 Q. Okay.

4 A. There's a difference between those  
5 two.

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

9 A. Correct.

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

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

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

22 A. Detect what?

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



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

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

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

11 A. Esterase.

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

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

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

19 A. It leads --

20 Q. Go ahead. I'm done.

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

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

1 true?

2 A. Among other things.

3 Q. What would some of the other things  
4 be?

5 A. Interstitial nephritis, reflux with  
6 stone disease. I mean, there's a lot of  
7 different things that pyuria can give you.

8 Q. Now, three plus blood in the urine on  
9 a urine dipstick is a serious amount of urine on  
10 a dipstick, is it not?

11 MR. FRASURE: Blood?

12 Q. A serious amount of blood on a  
13 dipstick, is it not?

14 A. It's positive.

15 Q. And it's positive in that it needs to  
16 be evaluated; true?

17 A. Yes.

18 Q. And especially, I think you told me  
19 before, you need to take into account the  
20 patient's signs and symptoms as well; correct?

21 A. Yes.

22 Q. So that if you have signs and symptoms  
23 that are -- strike that. I'll get to that in a  
24 moment.

25 So when you have hematuria, you would

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

4 A. Yes.

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

9 A. Yes.

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

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

21 Q. Yes.

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

25 Q. Yes.

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

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

10          A.     On what date?

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

18          A.     It may or may not.

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

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

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

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

4 A. Kidney disease, yes.

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

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

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

21 A. If I check off urinalysis, routine UA.

22 MR. FRASURE: On the requisition slip?

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

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

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

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

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

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

14 A. With reasonable certainty, I do.

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

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

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

4 Q. Okay.

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

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

12 A. Or somebody.

13 Q. Or somebody in the office; true?

14 A. True.

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

17 A. I do, yes.

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

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

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

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

9 A. Yes.

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

16 A. Qualified, yes.

17 Q. Like being kind of pregnant?

18 A. No. But --

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

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



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

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

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

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

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

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

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

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

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

22 A. To my knowledge, no.

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

1 otherwise; correct?

2 A. Say it again.

3 Q. He didn't order a urine culture  
4 either, did he?

5 A. To my knowledge, no.

6 Q. He did not order a renal panel either,  
7 did he?

8 A. I thought he got a renal panel. Can I  
9 check the records again?

10 Q. Sure.

11 A. All right.

12 MR. FRASURE: It's the next one down.

13 Q. While you're looking at that, I think  
14 you can probably look for it and answer my next  
15 question. What would be included in a renal  
16 panel?

17 A. Or sorry. Renal panel, as defined by  
18 City -- they vary. But at City, sodium,  
19 potassium chloride, bicarbonate, CO2, which is  
20 bicarbonate; that's how they measure it, BUN,  
21 creatinine, glucose, plus or minus calcium,  
22 depending on the lab, and albumin in some renal  
23 panels.

24 Q. Now, looking at the labs, did he  
25 obtain a renal panel?

1 A. He obtained more than that.

2 Q. Do you know why -- is that a good  
3 thing to have done at the lab?

4 A. Is it a good thing?

5 Q. I mean, is that helpful information?

6 MR. FRASURE: What he ordered or --

7 MR. MISHKIND: No. What was done.

8 A. Is this helpful?

9 Q. Yes.

10 A. Yes.

11 Q. Are you aware of whether or not Dr.  
12 Cola, in his requisition, in fact asked for a  
13 renal panel or not?

14 A. I saw that. Where is it? I did see  
15 that someplace.

16 Q. Let me show it to you just to save  
17 some time.

18 A. Okay. Thank you.

19 MR. FRASURE: Here it is.

20 A. He ordered a -- he crossed off renal  
21 panel, and he ordered a Chem 23, which  
22 encompasses the renal panel.

23 Q. He crossed off urinalysis and crossed  
24 off urine culture; correct?

25 A. Yes. Let me see it. Yes.

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

4 A. I have no idea, sir.

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

10 A. No, sir.

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

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

18 Q. Which is renal, which is kidney?

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

21 Q. Yes.

22 A. That's why I disagree.

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

25 A. Okay.

1           Q.       Which would be the urinary collecting  
2       system, the bladder and distal.

3           A.       Okay.

4           Q.       Can we agree that if a urinalysis is  
5       done and it shows dysmorphic red blood cells,  
6       that that is virtually diagnostic of kidney  
7       involvement?

8           A.       No.

9           Q.       Again, the literature that you have  
10      acknowledged to be generally reliable, that you  
11      have reviewed, you believe would support that  
12      contention?

13          A.       They haven't addressed that.

14          Q.       Certainly, we can agree that hematuria  
15      by dipstick does not distinguish microscopic  
16      bleeding which is registered as three plus that  
17      emanates from the kidney substance itself versus  
18      bleeding distally into the urine or the bladder  
19      or the urethra?

20          A.       No question about it.

21          Q.       In your report, you indicated that an  
22      earlier diagnosis would likely have resulted in  
23      less kidney damage?

24          A.       Yes, sir.

25          Q.       Tell me what you mean by that, with an

1 earlier diagnosis.

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

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

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

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

17 A. Roughly, yes, sir.

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

21 A. I'm happy for her.

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

1 dialysis at this point?

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

6 Q. She has permanent renal dysfunction;  
7 correct?

8 A. Correct.

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

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

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

18 A. True.

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

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

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



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

4 A. Give it to me again. Rephrase it.

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

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

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

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

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

21 A. True.

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

1 impacted her kidney damage; true?

2 A. No.

3 Q. Tell me why.

4 A. Could have. Not should have.

5 Q. Would persistent hematuria on repeat  
6 urine dipsticks demonstrate the need for  
7 microscopic urinalysis?

8 A. Standard of care would be that the  
9 patient should be evaluated, in this community.

10 Q. And that evaluation with the  
11 microscopic urinalysis can be initiated by a  
12 primary care doctor; correct?

13 A. The microscopic urinalysis?

14 Q. Yes.

15 A. Yes.

16 Q. In patients that have unexplained  
17 hematuria subsequently evaluated by microscopic  
18 urinalysis that have glomerular involvement or  
19 renal involvement, not all of them have  
20 proteinuria, do they?

21 MR. FRASURE: At what point?

22 MR. MISHKIND: At the early stages of  
23 the diagnosis.

24 Q. In other words, if you have three plus  
25 blood, you do a microscopic urinalysis, you

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

5 A. Well, up to 150 milligrams in a  
6 24-hour urine is considered normal, so you always  
7 have some.

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

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

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

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

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

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

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

1 out.

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

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

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

10 A. Some.

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

14 A. Correct. That's true.

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

20 A. Yes.

21 Q. We've covered that.

22 A. Yes.

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

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

4 A. I believe that, yes.

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

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

13 Q. Decreased urination, how is that?

14 A. Okay.

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

17 A. May or may not be.

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

21 A. May or may not be.

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

24 A. Nonspecific finding, maybe.  
25 Nonspecific.

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

5 A. And no other findings?

6 Q. As well as decreased urination.

7 A. And no other findings?

8 Q. Well, let's add in anorexia.

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

14 Q. Okay.

15 A. And not volume overload.

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

20 A. No.

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

23 A. No, not necessarily.

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

1 A. Not necessarily.

2 Q. Why do you say that?

3 A. There's a ton of other diseases out  
4 there.

5 Q. Well, isn't a primary care physician  
6 responsible for determining what most likely is  
7 causing --

8 A. Oh, I think that's a grandiose primary  
9 care physician that thinks that way.

10 Q. Why do you say that?

11 A. His responsibility would be to  
12 evaluate the patient to the best of his  
13 knowledge, and when he gets in over his head,  
14 make a referral.

15 Q. Certainly a primary care physician has  
16 a duty of responsibility to follow up on tests  
17 that he recommends and that he orders; correct?

18 A. Responsibility to follow up, yes.

19 Q. If a C-ANCA had been done and was  
20 positive, in this case, then a renal biopsy would  
21 likely have been performed?

22 MR. FRASURE: When, Howard? What time  
23 frame?

24 Q. If a C-ANCA had been done after  
25 microscopic urinalysis and it had been positive.

1 A. Positive for what?

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

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

7 Q. And what would that be consistent  
8 with?

9 A. In what context? Any context?

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

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

25 A. I got a glomerulonephritis.



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

4 A. With that data?

5 Q. Yes.

6 A. I'd look at the urine myself.

7 Q. Okay.

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

10 Q. Yes.

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

18 Q. Okay.

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

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

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

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

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

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

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

21 Q. Okay.

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

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

4             Q.     Why do you say that?

5             A.     Okay.

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

8             A.     It's scary if you get it.

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

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

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

6           Q.     But, doctor, just as we can't look at  
7   cases in retrospect, you can't look at cases a  
8   month later in terms of symptoms, and the  
9   question is: At that particular time on August  
10   27 of 1997, those symptoms that you looked at, by  
11   your own admission, were alarming to you on  
12   August 27; true?

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

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

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

25          Q.     Knowing that these symptoms of

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

9 A. Should have been evaluated.

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

12 A. I would have seen the patient.

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

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

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

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

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

1 A. It would have been reasonable.

2 Q. You don't see any evidence in this  
3 case, doctor --

4 MR. FRASURE: Did you answer the  
5 question, doctor?

6 Q. You answered my question, didn't you?

7 A. No. I had an addendum.

8 Q. You had an addendum to the question?

9 A. Addendum to the answer.

10 Q. Go ahead, doctor.

11 A. But I got to add that he knows this  
12 patient. He's got a better feeling for this  
13 patient than I do.

14 Q. I think you said that before.

15 A. Okay. All right. Go ahead.

16 Q. Doctor, there's no indication that Dr.  
17 Cola, from everything that you have read,  
18 intended to see this patient in the next day or  
19 within the next week or several weeks, was  
20 there?

21 A. I don't know if it was several weeks.  
22 I can't go that far. There was nothing that I  
23 saw that he intended to see the patient the next  
24 day. That's true.

25 Q. There's no indication that he intended

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

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

7 Q. Where do you get that from?

8 A. Her deposition stated that.

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

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

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

23 A. How do you know that?

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

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

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

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

8           A.       She was not --

9           Q.       Okay.

10          A.       -- to my knowledge told that.

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

15          A.       I honestly don't know that.

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

20          A.       Yes.

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



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

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

13          A.     Yes, sir.

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

19               MR. FRASURE:   Like in August or  
20    September?

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

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

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

1 know whether it was or it wasn't; true?

2 A. That's true.

3 Q. You can't rule it out being present in  
4 97; true?

5 A. Oh, true.

6 Q. Let's assume that it was there and  
7 that diagnostic tests were done that led to the  
8 diagnosis of Wegener's back in 97, okay?

9 A. Okay.

10 Q. If a diagnosis had been made of  
11 Wegener's back in 1997, can we agree that more  
12 likely than not the sequeli and the various  
13 complications with the respiratory symptoms, her  
14 blindness, the pancreatitis, and the multitude of  
15 complications she had, more likely than not would  
16 have been avoided had it been diagnosed back in  
17 1997?

18 A. I cannot say that, sir.

19 Q. Are you going to testify that she  
20 would have experienced those things anyway, or  
21 you're just not going to offer an opinion one way  
22 or another?

23 A. She could have, she may not have.

24 Q. You don't have an opinion one way or  
25 the other?

1 A. I really don't. These people relapse.

2 Q. I understand that. But she has not  
3 relapsed as of this date, has she, since she was  
4 treated?

5 A. With the records that I've seen?

6 Q. Yes.

7 A. She was treated in March, seemed to  
8 get over this, and then was again hospitalized in  
9 April.

10 Q. But since --

11 A. If you want to say that's a relapse,  
12 okay. If you say it's a continuation --

13 Q. She had a very high dose of  
14 corticosteroids administered to her when she had  
15 her first diagnosis of Wegener's; correct?

16 A. She had standard therapy.

17 Q. The Solumedrol that she had, did you  
18 happen to notice the dosage of Solumedrol that  
19 she received?

20 A. I don't recall it offhand, but I would  
21 probably say it was about a gram.

22 MR. FRASURE: Look if you want to.

23 Q. Let me suggest this to you, and you  
24 tell me whether this sounds accurate, okay, just  
25 try to save some time.

1 A. Here it is.

2 Q. Was the initial treatment including  
3 the Solumedrol?

4 A. Yes.

5 Q. Was it 30 milligrams intravenously  
6 every 12 hours on admission?

7 A. I'm looking at the ones that you were  
8 referring to. The initial admit orders does not  
9 have steroids in it that I see on 3-11-1998.

10 Q. On the 7th of April, was she given one  
11 thousand milligrams of Solumedrol intravenously  
12 as a bolus?

13 A. 7th of April?

14 Q. Yes.

15 A. She was given that before that, but if  
16 that's what you want to go to.

17 Q. And continued to receive a thousand  
18 milligrams intravenously every day until the 12th  
19 of April?

20 MR. FRASURE: April is in the black  
21 book.

22 A. But I remember seeing that. That's  
23 when they stopped the, if I remember correctly,  
24 they stopped the cytoxan during that time, didn't  
25 they?

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

3 A. No. I don't think so.

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

7 A. For who?

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

9 A. She didn't treat herself.

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

14 A. I'm looking for your orders.

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

18 Can you help him, Howard?

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

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

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

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

5 A. No.

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

7 A. No, sir.

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

11 A. Yes.

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

15 A. It's a common complication.

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

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

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

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

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

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

9 Q. Okay.

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

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

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

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

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

25 A. Yes, sir.

1 Q. There's no indication from her  
2 testimony as to what that additional testing was  
3 to be, was there?

4 A. Not to my knowledge.

5 Q. And, in fact, in the testimony of --  
6 or in the records, there's no indication that the  
7 doctor, other than in six weeks checking the  
8 liver enzymes, wanted to do any other additional  
9 testing; true?

10 MR. FRASURE: From the record you're  
11 asking him?

12 MR. MISHKIND: Right.

13 A. To my knowledge, not from the record.

14 Q. In the record, the doctor indicates he  
15 wanted to check the liver enzymes in six weeks;  
16 true, or did you not see that?

17 A. I want to review it. I think that's  
18 true.

19 Q. Okay.

20 A. But that's what I recollect. It does  
21 say recheck liver enzymes.

22 Q. It doesn't say anything about recheck  
23 the urine; correct?

24 A. Correct.

25 Q. Certainly, he had a plan noted to



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

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

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

8 A. It doesn't say anything.

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

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

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

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

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

1           A.     Yes.

2           Q.     Is there any indication on August 27,  
3     1997 that she was just calling to convey symptoms  
4     and had no desire of seeing Dr. Cola or having  
5     him treat her?

6           A.     There is no opinion either way.

7           Q.     Well, doctor, wouldn't you find it as  
8     remarkable if a patient called to tell the doctor  
9     here are the symptoms that I have and the  
10    receptionist notes, wants to know what this is,  
11    yet she has no intention of seeing the doctor for  
12    those symptoms, wouldn't you find that even more  
13    remarkable?

14          A.     What, that she has no intentions of  
15    seeing him?

16          Q.     If she called on August 27 and just  
17    gave him those symptoms but didn't have any  
18    intention or desire to see him on August 27.

19          A.     Obviously, by that note, she had a  
20    desire to continue to see him.

21          Q.     That's all I'm talking about, is on  
22    August 27th.

23          A.     Yeah. There's nothing that I would  
24    think is otherwise.

25          Q.     Again, going back, it says while the

1 patient saw these physicians in October, she did  
2 not see any primary care physician, including Dr.  
3 Cola, and you said with those symptoms on August  
4 27 -- I can't remember what the word you used  
5 was -- but some very explicit demonstration that  
6 there was a huge list of signs and symptoms that  
7 needed to be evaluated; true?

8 MR. FRASURE: Objection.

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

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

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

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

24 Q. Yes. Are you blaming the patient?

25 A. No, I don't blame patients.

1 Q. You don't --

2 A. See, I see this -- she's an adult.  
3 I'm not blaming her. But it's a two-way street.

4 Q. Okay.

5 A. It's a two-way street. If I come to  
6 you, if there's something that concerns me, or --  
7 and I don't get that message across to you, I  
8 have an obligation to make you realize what I'm  
9 thinking.

10 Q. There's a responsibility?

11 A. There is a responsibility, okay. Now,  
12 she saw two other physicians, and from the way I  
13 read those records, it was apparent to me that --  
14 I forgot which one of them; one of them said  
15 she's going to see Dr. Spoljaric in a couple of  
16 weeks.

17 Q. You're talking about Dr. Torok's note  
18 on September 14th or 11th?

19 A. Whenever it was.

20 Q. Okay.

21 A. So, again, if Torok -- just having  
22 been in this awhile, if Torok knew that, and he  
23 transmitted anything, he would be transmitting it  
24 to Spoljaric. So Cola wouldn't have necessarily  
25 gotten that information. I don't know. So

1     there's a lapse here.

2           Q.     You don't know, do you, what efforts  
3     Vickie Migllore made to get in to see Dr. Cola  
4     after she made this telephone call on August 27,  
5     1997, other than what you see in these notes;  
6     correct?

7           A.     Other than what I see in the  
8     deposition.

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

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

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

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

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

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

4 A. One message on a machine?

5 Q. Correct.

6 A. In my opinion, no.

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

10 A. No, sir.

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

13 A. Yes.

14 Q. And there's no indication on September  
15 4 that anyone notified Vickie at that point, oh,  
16 by the way, we've got a prescription for you, we  
17 want to send you to a referral, we want to  
18 schedule you for something, is there?

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

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

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

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

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

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

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

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

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

10          A.     No, sir.

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

13          A.     I've seen this.

14          Q.     Okay.

15          A.     My copy.

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

21          A.     Shirach is the GI doctor?

22          Q.     Correct.

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

25          Q.     As of October 24, 1997, can we



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

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

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

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

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

16 A. I don't know that.

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

21 A. Okay. SWOP.

22 MR. FRASURE: Spoke with on phone.

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

25 Q. But you have reviewed the case and

1     you're testifying as an expert in this matter.

2     Tell me, based upon the information from Dr.

3     Shirach's office, what test results were provided  
4     to Dr. Shirach.

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

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

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

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

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

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

25            Q.     We know that based upon that, and can

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

5 A. The liver.

6 Q. Right.

7 A. I would assume that's true.

8 Q. Okay.

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

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

13 A. Correct.

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

18 A. Neurologist?

19 Q. Neurologist, yes.

20 A. Okay.

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

23 A. On what day?

24 Q. August 27th.

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

1 Q. All right. I'm sorry.

2 A. I can't say that.

3 Q. Why is that?

4 A. Why is that that I can't say that?

5 Q. Yes.

6 A. Because I am not aware of how  
7 comfortable Dr. Cola felt with these symptoms.  
8 I'm not aware of how comfortable he felt with the  
9 previous ten years of this patient, how well he  
10 knew her. There is a lot that goes in there,  
11 and, again, sometimes you read between the lines  
12 on these patients. Remember, his notes are  
13 handwritten. And, I mean, that's not as fast and  
14 you don't include as much as when you dictate.

15 Q. Doctor, having said that, we know that  
16 the referral to the neurologist had not taken  
17 place, we know that at least as of October 24,  
18 1997, Vickie had not been notified, nor had two  
19 other doctors that had seen her, been notified of  
20 unexplained hematuria; correct?

21 A. From the notes that were in his  
22 charts, you're right.

23 Q. And from all of the evidence that you  
24 have reviewed in this case, my statement is  
25 accurate; correct?

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

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

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

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

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

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

20          A.     I think we do send out a card.

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

23          A.     I think we do, yes.

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

1 to see if hematuria was still present; correct?

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

4 A. I believe it should have been followed  
5 up.

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

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

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

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

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

22 A. Microscopic you said?

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

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

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

9 A. If that case scenario came up, true.

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

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

21 Q. Are you saying those are two different  
22 things?

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

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

5 Q. Okay.

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

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

14 A. That had taken place.

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

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

21 Q. Why do you say that?

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

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



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

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

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

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

13          A.     Oh, I think he would see her.

14          Q.     When?

15          A.     She wanted to come in earlier.

16          Q.     Was she given an appointment?

17          A.     Did she make one?

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

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

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

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

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

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

9 A. Retrospectively?

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

13 A. Right.

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

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

18 Q. Was there?

19 A. No.

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

23 A. Yes.

24 Q. That's a yes?

25 A. Yes.

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

4           A.     I don't know.

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

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

15          Q.     Yes.

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

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

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

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

5           A.     Salvage.

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

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

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

16          A.     Assuming it was present then.

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

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

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

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

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

6           A.     She may have.

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

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

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

17          A.     I believe that's true.

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

23          A.     She's not end stage.

24          Q.     Didn't she go into end stage?

25          A.     She went into acute renal failure.

1 End stage is end stage.

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

4 A. Is not end stage.

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

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

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

1 Q. Yes.

2 A. Yes.

3 Q. Would you agree that, given her  
4 current condition with 30 to 34 percent  
5 creatinine clearance, that, and given the extent  
6 of her renal disease, that she has lost  
7 essentially 50 to 65 percent of her normal renal  
8 function?

9 A. How old is she now?

10 Q. 50.

11 A. I'll give you 40, 50, yes, she lost.

12 Q. Is she, because of her current  
13 condition, irrespective of whether she has a  
14 flare-up in her Wegener's, is she at increased  
15 risk of renal failure over someone else of her  
16 same age without this much loss of renal  
17 function?

18 A. Correct.

19 Q. What is it about this much loss of  
20 renal function at her age of 50 that makes her a  
21 greater risk than someone with no renal failure?

22 MR. FRASURE: Objection. I think the  
23 comparison should be versus if an earlier  
24 diagnosis had been made in the fall.

25 MR. MISHKIND: You can put it to him

1 that way at trial.

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

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

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

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

14 MR. MISHKIND: Right.

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

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

25 A. Any disease, right.



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

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

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

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

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

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

1 MR. MISHKIND: Let me ask the  
2 questions.

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

6 A. Do I know it will have an impact?

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

10 A. Based on the renal disease?

11 Q. Yes.

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

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

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

18 Q. Why is that?

19 A. Because it's damaged.

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

1 dysfunction that they have?

2           A.       They may or may not have problems from  
3 their renal disease as time goes on, okay. When  
4 you get down to the individual case, I don't know  
5 what the status of her heart is, I don't know  
6 what the status of other organs in this patient  
7 are. She is 50 years old. The assumption, if  
8 you want to make any assumptions, she has  
9 coronary artery disease. I've never laid eyes on  
10 this lady, but from living here in this country,  
11 from what I have seen, she's on the heavy side,  
12 50 years old, she has coronary artery disease as  
13 a given. Obviously, she has renal  
14 insufficiency. You're asking me if, more likely  
15 than not, is it going to be the renal disease  
16 that does her in. That's what I understand  
17 you're asking me, and I'm saying I don't know.

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

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

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

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

5 A. Ballpark figures, 50 percent.

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

8 A. Right, yes.

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

11 MR. FRASURE: Has he ever treated or  
12 currently?

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

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

17 Q. How many have you treated all told?

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

20 MR. FRASURE: I'm sorry?

21 THE WITNESS: About 15.

22 MR. FRASURE: 15 or 50?

23 THE WITNESS: 15.

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

1 diagnosed and they had experienced some renal  
2 disease?

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

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

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

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

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

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

7 Q. It's an uncommon disease; correct?

8 A. Right.

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

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

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

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

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

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

1 the patient; correct?

2 A. He was concerned with arthritis.

3 Q. Right. And he thought that it might  
4 be some type of an inflammatory or arthralgia  
5 type of condition; true?

6 A. He was concerned with -- yes.

7 Q. But he didn't have the benefit of  
8 hematuria at that point; correct?

9 A. Based on what we see, no.

10 Q. That would have been helpful, would it  
11 not?

12 A. To Torok?

13 Q. To whoever is going to work the  
14 patient up for the cause of her inflammatory  
15 symptoms or her arthritic symptoms to determine  
16 whether or not they're secondary to a  
17 vasculitis.

18 A. Torok was an orthopedic surgeon, was  
19 he not?

20 Q. Yes.

21 A. Orthopedic surgeon may or may not have  
22 placed much weight in that urine. A nephrologist  
23 obviously would have. A rheumatologist probably  
24 would have. That's just the way I look at it.

25 Q. We know that he wasn't provided that

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

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

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

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

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

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

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

23 A. Yes.

24 Q. That's a yes?

25 A. Yes.



1 (Discussion off the record.)

2 MR. MISHKIND: Mark, on the record,  
3 I'm taking this doctor's deposition who was  
4 identified to me just a week ago, and I'm  
5 entitled to take a discovery deposition of him,  
6 so whatever time it takes me, I will take.

7 Q. We talked earlier about C-ANCA and  
8 whether -- I think it was in the context of  
9 whether it would or would not have been ordered.

10 A. Right.

11 Q. Do you remember that?

12 A. Right.

13 Q. Is a C-ANCA a very specific antibody  
14 or test for Wegener's granulomatosis?

15 A. How do you mean specific?

16 Q. When one is looking at laboratory  
17 studies that are done that lead one to diagnose  
18 Wegener's, is C-ANCA and P-ANCA specific  
19 laboratory findings that have a high correlation  
20 to Wegener's, if positive?

21 A. The sensitivity or specificity of  
22 those tests are such that yes; however, it  
23 depends on the prevalence of the disease.

24 Q. Explain to me.

25 A. The prevalence of a disease, if you

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

5 Q. Okay.

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

13 Q. I'm not suggesting that it is.

14 A. Okay.

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

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

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

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

1 the disease, yes.

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

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

11 A. I don't think so.

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

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

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

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

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

25 MR. FRASURE: Dr. Hadley

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

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

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

8 A. No, sir.

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

11 A. Yes, I believe he did.

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

16 A. I think that's nonspecific.

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

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

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

23 A. Do not. I do not.

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

1 diagnosis of Wegener's granulomatosis?

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

4 Q. Do you?

5 A. That he caused a delay?

6 Q. Exactly.

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

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

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

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

16 Q. So my statement is correct; correct?

17 A. Say your statement again.

18 Q. You don't believe he was negligent?

19 A. I don't believe he was negligent.

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

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

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

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

7 MR. FRASURE: Objection.

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

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

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

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

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

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

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

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

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

22          A.     Concerning Cola and Spoljaric, yes.

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

25          A.     We didn't get into the City Hospital

1 records.

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

5 A. No.

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

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

10 Q. Okay.

11 A. Yes.

12 Q. All right.

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

22 THE WITNESS: No, sir.

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



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

3 THE WITNESS: My opinion, no.

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

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

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

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

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

19 A. No. I just saw his letter.

20 Q. You haven't seen his deposition?

21 A. No.

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

25 A. The treatment of choice, in my

1 opinion, is steroids and cytoxan.

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

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

9 Q. Okay.

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

12 Q. Do you know Dr. Zizic?

13 A. No.

14 Q. Do you know him by reputation at all?

15 A. No, sir.

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

20 A. To my knowledge, yes.

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

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

24 - - - - -

25

1 AFFIDAVIT

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

5 PAGE LINE REQUESTED CHANGE

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18 \_\_\_\_\_  
KARL D. SCHWARZE, M.D.

19

20 Subscribed and sworn to before me this

21 \_\_\_\_\_ day of \_\_\_\_\_, 2000.

22

23

24 \_\_\_\_\_  
Notary Public

25 My commission expires \_\_\_\_\_.

CERTIFICATE

[illegible]

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.

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