IN THE COURT OF COMMON PLEAS
OF ATHENS COUNTY, OHIO

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JUDITH SAVAGE, ET AL.,
Plaintiffs,
vs. Case No.
O'BLENESS MEMORIAL
HOSPITAL, ET AL., 98 CI 000217
Defendants.

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DEPOSITION OF ROBERT L. TOMSAK, M.D., Ph.D.
Thursday, July 13, 2000

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Deposition of ROBERT L. TOMSAK, M.D., Ph.D., a witness herein, called by the Defendants for examination under the statute, taken before me, Karen M. Patterson, a Registered Merit Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at the offices of Becker & Mishkind Co., L.P.A., Suite 660 Skylight Office Tower, 1660 W. 2nd Street, Cleveland, Ohio, at 10:25 o'clock a.m. on the day and date set forth above.

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APPEARANCES:

On behalf of the Plaintiffs:

Becker & Mishkind Co., L.P.A., by
HOWARD MISHKIND, ESQ.
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On behalf of the Defendants:

Law Office of Patrick F. Smith, by
PETER VAN LIGTEN, M.D., J.D.
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Columbus, Ohio 43220
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ROBERT L. TOMSAK, M.D., Ph.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF ROBERT L. TOMSAK, M.D., Ph.D.

BY MR. VAN LIGTEN:

Q. Good morning, Dr. Tomsak, my name is Peter Van Ligten, and I'll be asking you some questions regarding Judith Savage.

Just some preliminary ground rules. I'll be asking you questions. If you don't understand my questions, please let me know and I'll rephrase them. Try not to guess at answers. If you don't know or need to speculate, just let me know that you don't have the necessary information to give me an answer.

Please respond verbally, as the court reporter has a hard time with nodding your head or uh-huhs. Those don't transcribe well.

Let me just start, I was handed this curriculum vitae. Is this your current curriculum vitae?

A. Yes, I believe it's current as of October 1999. There's a date down there, but

nothing significant has changed from that interval till now.

Q. What is your current position?

A. I am employed by Lakeland Eye Surgeons, which is a group of private ophthalmologists in Lorain County.

Q. So you're in private practice?

A. Yes.

Q. Is that group affiliated with any hospital or medical system on a contractual basis?

A. Not to my knowledge. We do have our offices in the Cleveland Clinic Lorain Building. Again, as an employee, I don't know the financial ins and outs of the arrangement, but my understanding is that the Lakeland Eye Surgeons group is freestanding and just simply rents space from the Cleveland Clinic.

Q. Are you a faculty member at the Cleveland Clinic?

A. No, but I am a faculty member at Case Western Reserve University. I'm clinical associate professor of ophthalmology and neurology.

Q. Do you at times have medical students

rotating with you?

A. Not at the present time, but I do attend at the Cleveland VA Hospital eye clinic once a month. So at that time I do actually have a neuro-ophthalmology clinic which residents bring patients back for, and we don't usually have medical students on that rotation, but if they were there, I would be instructing them.

Q. And the residents there are Case Western residents?

A. Yes.

Q. In ophthalmology, I take it?

A. Correct, but they also have a busy optometry practice, so I also teach the optometrists, to some degree, but the same location.

Q. And how long have you been with the Lakeland group?

A. Just about two years. I joined -- I actually started in May, but my contract was signed August 7th. So it will be, I guess, physically a little over two years, and contractually, not quite two years.

Q. And before that time, what kind of practice, or who were you employed by?

A. Before that time, I was employed by Mt. Sinai Medical Center. And, as you know, they went under financially, and that really prompted my move. Had they remained open, I would have stayed in my position, which was basically having a clinical neuro-ophthalmology practice, but also being the only full-time attending, meaning on-site attending. So about 50 percent of my time was doing neuro-ophthalmology, and about 50 percent -- in a private setting, and about 50 percent was resident education and overseeing the clinics.

Q. At the time you examined Judith, were you working for Mt. Sinai?

A. What date is that? I think it was shortly --

Q. 3-26, I believe.

A. Oh, I definitely was, yes, and I was also spending part time in Dr. Levine's office, and that's what that letterhead refers to. I was doing a half day a week in a private practice setting also doing clinical neuro-ophthalmology.

Q. Now, your note here reflects that you were requested to see Mrs. Savage by Mr. Mishkind. Have you done previous consultations

or examinations on his behalf?

A. Not to my knowledge.

Q. Have you ever reviewed cases for a medical malpractice purpose?

A. Yes, I have.

Q. How long have you been doing that, sir?

A. Probably since I finished my fellowship. I would say since 1980.

Q. And how many cases currently in a year would you say you review?

A. I would say about five, six.

Q. And is that about where it's been throughout your career, or is that higher or lower?

A. I'd say it's a good average. I don't think I've ever done more than seven or eight in a year.

Q. In terms of, if you can tell me, those cases that you do review, can you divide those into the patient or Plaintiff's side versus the physician Defense side?

A. I would say the vast majority are physician Defense.

Q. And, if you can, just give me a

general idea of the states where some of these cases have arisen from.

A. The vast majority in Ohio. I can remember the first one I did was actually a Florida-based case, and I had seen the Plaintiff as part of my fellowship duties, actually, and I recently was involved in a case, actually still am, from, I think, Michigan, but almost all are from Ohio.

Q. So Ohio, Florida, Michigan?

A. Yes.

Q. Have you personally been involved as a party in any lawsuits?

MR. MISHKIND: Objection, but you can go ahead and answer.

A. Okay. I was sued once, but it was dropped without prejudice.

Q. Have you ever testified in a deposition before?

A. Yes, I have.

Q. Approximately how many times, sir?

A. Well, let's see, in that 20-year period, maybe 20 times.

Q. How many times would you estimate you have testified at trial?

A. Just once.

Q. Would you happen to recall the name of the case or the patient name or the doctor's name?

MR. MISHKIND: The trial testimony?

MR. VAN LIGTEN: Yes, on the trial testimony.

A. I'm really not sure, but I can tell you it was a case that was defended by the firm Jacobson, Maynard that is no longer -- everybody's smiling.

Q. Was it in Ohio, sir?

A. Yes, it was, and I think it was in Akron. I think that's where the trial was, yes.

Q. Do you have any personal or professional relationship with Mr. Mishkind or any other member of this law firm?

A. No.

Q. Any personal or financial relationship with the Plaintiffs?

A. No.

Q. Have you reviewed cases for this firm previously?

A. Not to my knowledge.

Q. Since I have your CV, I won't go over

that any further, but just in general, I saw your list of publications. Have you been involved in any type of academic work or published any papers or presented any papers which are on point to the issues in Mrs. Savage's case?

A. Well, if you look at my CV, I have been involved in the publication of two books; one that I solely authored and another that I edited, and I think it's called Pediatric neuro-ophthalmology. Can I just look at this and I'll tell you for sure?

Q. Sure.

A. I think that we're missing some pages here, unfortunately, or they're out of order.

MR. MISHKIND: Off the record.

(Discussion off the record.)

A. Here we go. Pediatric neuro-ophthalmology, and that's the literature citation there. Anyhow, I wrote a chapter, I personally wrote a chapter, in that on what we call functional visual loss. It was aimed more towards the pediatric side of the problem, but it does have some relevance to adult patients with this sort of problem.

Q. I guess I'll ask, would you consider

your article on functional visual loss a reliable publication?

A. Yes. I would just qualify that by saying I think it's probably vintage 1996 or so, and I really haven't reviewed the literature since then, but I think it's a good summary. It contains what I consider to be the, you know, the better references that deal with that topic.

Q. Are there any other pieces of literature in your CV that relate to the issues in this case?

A. I don't believe so, but if you'd like, I could go through them one-by-one.

Q. If you would.

A. I don't mind.

Q. Unfortunately, they're not in order. We'll give you all the time you need.

(Discussion off the record.)

A. Actually, this kind of will take me a minute to describe to you, but there is a company that's called Audio Digest, and they basically summarize verbal presentations at meetings, make tapes of them and sell the tapes. And, anyhow, one of my presentations, it looks like back in 1985 was taped and sold, I suppose at no

remuneration to me, by the way, but it's entitled Functional Visual Loss, but, again, that was 1985.

Q. Can you tell me what materials you were given to review for this case in order to help you form an opinion?

A. Yes. I have a copy of my report dated Thursday, May 14th, 1998. I have Dr. Carl Asseff's report. I have Dr. McAdoo's notes, and I have the hospital records from is it O'Bleness, is that -- O'Bleness Memorial Hospital.

Q. Were you given any depositions, sir?

A. No.

Q. Did you review any literature or do any research to help form the basis of your opinions?

A. No.

Q. Didn't even review your own articles?

A. No, I didn't, actually.

Q. And I take it that you have formed one or more professional opinions regarding Mrs. Savage?

A. Yes. The opinions I have formed are detailed in my report letter to Mr. Mishkind.

Q. Can you tell me what your opinion is

as to Mrs. Savage's current diagnosis or diagnoses?

A. As to her eye?

Q. Yes. I'm sorry.

A. I would say they would be two. One would be recurrent corneal erosion syndrome, and the next one would be functional or nonorganic visual loss.

Q. And let's start with the first one, recurrent corneal erosion syndrome. Can you tell me what that is, sir?

A. Well, recurrent corneal erosion syndrome is usually seen in the setting of corneal trauma where the basement membrane of the corneal epithelium is damaged, so that the epithelium, when it reheals, is not as sticky as it normally is. And what normally happens is that from time to time the epithelium will actually slough off and expose the pain-sensitive nerves at the base of the epithelium leading to symptoms like mini corneal abrasions, basically.

Q. And how is that diagnosis made?

A. The diagnosis is usually made historically by prior history of a corneal abrasion or other corneal injury and then by the

symptoms of intermittent episodic stabbing pain. That's basically it.

Q. Are there any physical findings present to help you make this diagnosis?

A. Sometimes yes and sometimes no. Sometimes when looking at the slit lamp, which is our microscope that we use to examine the eye, one can see an area where there is an abnormality of the basement membrane of the cornea or a small scar in what's called the anterior stroma of the cornea. But very often one doesn't see the abnormal area unless the patient is examined at the time they're symptomatic.

Q. And the character of the pain, how would you describe that in this syndrome?

A. It's usually sharp, severe, usually associated with a light sensitivity, sometimes lacrimation; in other words, tearing.

Q. And how long does that painful episode last?

A. It really depends on the severity. It can -- usually it's something that if ocular lubricants are put in the eye it goes away relatively rapidly, within a period of minutes to an hour or so, or if the person closes the eye

and just rests the eye with the eye closed.

Q. In terms of the frequency of symptoms, how often do you expect painful episodes to occur with recurrent corneal erosion syndrome?

A. It really varies all over the ballpark. I would say usually -- well, again, I really can't tell you. It can go anywhere from once a year or once every couple of years to being on a daily basis. It's kind of dependent on the severity of the syndrome.

Q. If I understand you right, the pain is caused by nerve irritation; is that correct, sir?

A. Right. The cornea is the most pain-sensitive part of the human body. Whenever the corneal epithelium, which is the outer layer of the cornea, outer with respect to the air, is damaged, then the pain nerves that are right under the epithelium become stimulated, and that's where the pain comes from.

Q. Would that require, for pain to occur, a defect in the epithelium?

A. Correct.

Q. And --

A. For this type of pain to occur.

Q. Yes. So if I understand you correctly, every time there's pain, there's a corneal epithelial defect that occurs?

A. Yes. It may be on a microscopic level, but basically, I think that's the best way to look at it pathologically.

Q. How does a lubricant help alleviate that pain?

A. Well, I think what the lubricant does is it essentially covers over the damaged area and acts as a bandage, in a sense, and it just simply makes the pain better as far as that goes.

Q. Is it known why, in these instances or in this condition, the epithelium couldn't reheal to the basement membrane?

A. Well, the thought is that the basement membrane is damaged, so it's almost like a pot hole in the road, it's an area where the structural integrity of that particular part of the cornea is not normal, so the epithelium just doesn't attach to it as it normally should.

Q. Is there any definitive treatment for this, sir?

A. Well, other than lubricants, I believe for awhile, a few years ago, people were talking

about what's called corneal tattooing, where actually you would puncture the abnormal area with a fine needle and actually cause sort of a scar, small scars to form, that would hold the epithelium down, but I really haven't seen that in the general ophthalmology literature recently. The other thing I suppose that could be tried would be a soft contact lense, bandage contact lens. Again, that requires a fair amount of maintenance and is one of these things that could, you know, sometimes become more problematic than the underlying condition if the contact lens is not taken care of correctly.

Q. Is corneal transplanting an option?

A. I don't think it would ever be indicated. A corneal transplant is one of these procedures that the lay public looks at and, you know, thinks it's kind of miraculous in the sense that, you know, you get your sight back. But the fact of the matter is a corneal transplant is an extremely time intensive operation for the patient in the sense that they have to be on drops basically for the rest of their life. They have to come back to the doctor every couple of days after the surgery for awhile. Their vision

is never really clear. So we reserve corneal transplants for blinding corneal conditions. Another way to say it would be the risks of the procedure far outweigh the benefits in that particular instance.

Q. Is there anything that can be done to minimize or reduce the number of painful episodes or recurrent episodes of corneal detachment or --

A. Yes. The standard of care is to use some sort of a lubricating ointment during the night, and we have a number available that are of different chemical compositions in order to lubricate the surface of the cornea between the eyelid so that, upon awakening, the opening of the eyelid doesn't cause the abrasion to occur. That's number one.

And then number two would be some sort of a lubricating drop during the day. Again, if you go to the pharmacy, you'll see 20 different types of artificial tear substitutes, and they all have different chemicals in them, and they all are touted to do certain special things. So it's kind of a hit-and-miss sort of proposition.

But what I would do would be -- meaning if I was treating a patient with this

problem, I would have them experiment to try to see which tear seems to make them less symptomatic.

Q. Dr. McAdoo has seen Mrs. Savage several times after the initial injury, and aside from the early course, he's not ever seen any recurrent corneal injury or damage. Does that comport with the diagnosis of recurrent corneal erosion syndrome?

MR. MISHKIND: Doctor, before you answer, let me just indicate on the record, he just faxed up the pages, and, if you want, I can actually hand this to the doctor before he answers the question.

MR. VAN LIGTEN: That's fine.

MR. MISHKIND: This is a May 28, 1999 visit and then a May 3, 2000 that the doctor faxed up from yesterday's deposition. We'll run off a copy before you leave.

MR. VAN LIGTEN: Sure. We can pause here for a couple of minutes.

(Pause.)

A. I'm ready. Would you mind asking me the question again?

Q. Sure. If I remember right, there was

a period just after her surgery and the injury to her cornea where there were some abnormalities of her cornea visible.

A. Correct.

Q. Subsequent to that time, however, on a subsequent visit, no identifiable injury has been seen by Dr. McAdoo?

A. Yes, I understand that.

Q. And is that inconsistent with this diagnosis? Is it very understandable, or unexpected, I guess? What is your impression of that?

A. Right. Well, I think there are a couple of issues at hand. First of all, if she is not actually symptomatic at the time that the exam is done, it's very possible that you will not see anything, okay.

Number two, at least on this note of 5-28-99, there's a statement here that she has ointment in her right eye. So that would really obscure the finding if it was there to a small degree. I don't know if that answers your question.

Q. Well, let me put it hypothetically.

A. Okay.

Q. If a patient with recurrent corneal erosive syndrome had multiple eye examinations over a 12 or 18-month time period without any evidence, would that contradict that diagnosis or would it still be consistent with the diagnosis?

MR. MISHKIND: Objection. Before you answer that, in that hypothetical, are you including or excluding ointment from the eye?

MR. VAN LIGTEN: No ointment, without ointment.

MR. MISHKIND: Let me just show an objection, but you can go ahead and answer the question.

A. My answer to that would be, again, if the person came into the office while they were acutely symptomatic, it's not uncommon to see it, a corneal defect, an epithelial defect. But if it's one of these things, I woke up this morning, my eye felt like someone stabbed me with an ice pick and I laid down on the couch and closed my eyes and 30 minutes later I feel better, but I really want to come see you today, and I examine the person at 2:00 or 3:00 in the afternoon, it would be very consistent for me not to find any abnormality.

Q. So those corneal injuries that occur with this syndrome would heal to objective inspection within how many hours?

A. Depends on how big they are. In other words, it's a surface area issue, in the sense that I was mentioning to Mr. Mishkind earlier, that the size of a corneal defect, in a sense, kind of can tell you by estimate how long it's going to take to heal, you know, all things going correctly. But we're usually talking about extremely small defects in the recurrent erosion syndrome; nothing like, for example, what's documented in the chart after her surgery.

Q. Is there a correlation with size of injury and degree of pain?

A. For sure. Absolutely.

Q. So is there a minimum amount of injury you have to sustain to suffer severe stabbing pain?

A. Well, again, I think I've said before that the cornea is really one of the -- I think is the most pain sensitive structure in the human body. I think I've said that before, and even extremely small lesions, so to speak, can be extremely painful.

And I'll just give you an example of something that's related but not directly germane to this, and that is the whole issue of getting foreign bodies in the eye. In my present practice situation, I see a lot of industrial accidents where something flies into a person's eye and then they come in, you know, because they're feeling extremely uncomfortable and they have a lot of tearing and redness, and to make a long story short, oftentimes the foreign body is so small that even with a needle, let's say 25-gauge or 27-gauge, the tip of the needle under the microscope looks even bigger than the foreign body. So I'm just giving you this as an example of an extremely small lesion that can cause a tremendous amount of symptoms.

Q. When you examined Mrs. Savage on March 26, 98, did you find any evidence of corneal injury?

A. No, I didn't.

Q. Did you find any abnormalities at all on her eye examination?

A. Yes, I did, in terms of her visual function.

Q. And what were those abnormalities?

A. Her visual acuity in the right eye was subnormal. I had measured it at 20/200 at distance and the near equivalent of 20/100.

Q. And how was the 20/200 measured, sir? How did you do that?

A. Well, the way an ophthalmologist measures distance acuity is the person is in an exam chair, standardized distance away from the chart that's projected on the wall, and the scale that we use is something that was actually dreamed up in the mid 1800s by a man by the name of Snellen, S-N-E-L-L-E-N. And, essentially, Dr. Snellen felt that a person who could see a standardized image at a certain distance, namely 20 feet, was normal. And that's the 20/20 notation.

20/200 means that a normal person could be 200 feet away from an object that a person who has 20/200 vision would have to be 20 feet away from to see. So distance vision is, in an ophthalmology office, is measured on a standardized distance from a projector. Near vision is measured with a card that a person holds at 14 inches, normally at 14 inches.

Q. From my experience in having my eyes

checked, a lot of that depends on the person being examined; is that a fair statement?

A. Yes, it is.

Q. It would be difficult to make your vision appear better than it was; is that correct?

A. Yes, it would be difficult.

Q. But it would be possible to make your vision appear worse than it was?

MR. MISHKIND: Objection, but you can go ahead and answer the question.

A. Yes, it is possible.

Q. Is it possible for an ophthalmologist to determine the actual refractive capacity of the eye?

MR. MISHKIND: Objection, but go ahead and answer, doctor.

A. The answer to that question is yes.

Q. And how is that, doctor?

A. Okay. You were headed down one path and you changed and diverted yourself. Do you want me just to address the refractive issue right now?

Q. Yes.

A. Refraction really refers to the use of

lenses to neutralize the optical error of a person's eye. So, for example, I'm nearsighted, plus I also have what's called presbyopia, I have a need for reading correction, and using special instruments, it's possible to objectively measure a person's refractive error by shining a special light in their eye and neutralizing a reflex that we observe through these instruments. So that's our first step.

Q. And did you do that in Mrs. Savage?

A. I believe I did.

Q. And what result did you get?

A. Well, you know, I may have to go back and say I don't have her refraction written down here, so I'm not really sure if I did.

Q. What other kind of methodology do you have in your armamentarium to decide or determine whether the patient is actually giving you the true response in terms of their visual acuity?

MR. MISHKIND: Objection. But go ahead.

A. Well, one thing we always do in a person who has subnormal vision in one eye versus the other eye is we check to see how their pupils react to light, and the reason for that is that a

person with a significant optic nerve problem or even retinal problem whose vision is 20/200 normally has a pupil that does not react as well on that side when compared to the other. We call that an afferent pupillary defect. In this case, she did not have an afferent pupillary defect.

The other thing we do is look at the eye, the structural integrity of the eye, to make sure that there's not anything that would be an explanation for that reduced vision such as a corneal scar, a cataract, vitreous hemorrhage, retinal problem like macular degeneration or branch vein occlusion, et cetera, et cetera.

So it's refraction, checking the pupils, checking the structural integrity of the eye. And then the other thing that's extremely important and germane to Mrs. Savage's case is that I did a visual field analysis by two different methods, and that's essentially checking the peripheral vision, which is a whole different form of vision than what we read on the eye chart. And her peripheral vision in that right eye was abnormal, but it was inconsistently abnormal.

Q. What does that mean when it's

inconsistently abnormal?

A. Well, could you ask it another way? I'm not -- you mean what does it mean in terms of what goes through my mind at that time?

Q. Well, you said it was inconsistently abnormal. My impression of that statement is that you shine the light in one part of her visual field; on one response she sees it, on another response she doesn't see it. Is that what you're meaning or --

A. No.

Q. I'm just trying to figure out what you meant by that.

A. No problem. What I did is I did what's called a confrontation visual field initially, meaning I covered her left eye and sat across from her about this distance (indicating) and held up fingers in different areas of her visual field and I asked her to count them as she looked at my nose with her eye. That's a gross measure of peripheral vision. We call that a confrontational visual field.

What I found on that, according to my report, was that there was an abnormality in the upper nasal visual field of her right eye. That

would be, if I'm looking at you with my right eye, that would be this area up here (indicating).

We then did a test on a computerized machine called an automated perimeter that uses a very sophisticated computer-driven strategy, measures the actual visual threshold of the visual field at various points in space. And that was abnormal, but it showed a defect in the temporal peripheral visual field of her right eye. In other words, the confrontation field result and the automated perimetry result did not coincide with one another, but they were both abnormal.

Q. Is there any anatomic or physiological finding in Mrs. Savage's eye that would account for those test findings?

A. No.

Q. Let me just ask you in general. Is there anything that you saw in your examination that was abnormal on her -- let's start from the back forward, from the retina; did you see any abnormality in the posterior aspect of the eye?

A. No.

Q. The lens appeared normal to you?

A. Correct.
Q. And the anterior components were also normal?
A. Correct.
Q. So anatomically, at least to inspection, everything seemed to be okay?
A. That's correct.
Q. And are you aware that Mrs. Savage had a fluorescein angiogram done?
A. I believe I saw that notation somewhere, but I don't believe I know the results of the test.
Q. You did not review those films or those --
A. No, I did not.
Q. She also had an MRI done of her brain and optic nerve, I believe, whatever ophthalmologists scan to look for visual acuity loss, and were you able to review those films or --
A. I don't believe I did.
Q. -- or reports?
A. I don't believe I did, but it wouldn't surprise me if they were completely normal. I presume that that's what the result was.

Q. The recurrent corneal erosion syndrome would not account for her visual acuity deficits?

A. Correct, with one small caveat, obviously, if she had the ointment in her eye at the time of the exam, but other than that, we would expect that to get better as the ointment was blinked out of the eye.

Q. Have you had any patients prior to Mrs. Savage with this problem, sir?

A. Which problem?

Q. The recurrent corneal erosion syndrome.

A. Yes, I have.

Q. How common of a malady is this?

A. Well, how should -- what term shall we put this in?

Q. What's the relative incidence or frequency in the population?

A. How about if we do it this way, because I have no idea, to be honest with you.

Q. Okay.

A. How about if we use our frame of reference in a general ophthalmology practice. In other words, in a month how many people with

recurrent corneal erosion syndrome would I see. I would say something like two. And we're talking about, let's say, in reference to my patient volume, maybe 500 patients a month, so whatever that works out to be. But that's only my personal experience. I don't know what, if any, formal reports have been done or reviews of the literature.

Q. Would this be in your practice?

A. My personal experience is what I said.

Q. Right.

A. It just refers to me only.

Q. You had mentioned general ophthalmology, and I take it you're a subspecialist?

A. I am, but in my present venue, which hopefully will change very shortly, I am mainly doing general ophthalmology, yes.

Q. So two out of 500, that's not very rare.

A. Well --

Q. I guess.

MR. MISHKIND: Is that a question or a comment?

Q. It surprises me it's that common

because I never heard of this.

MR. MISHKIND: I'll take it that's a comment rather than a question.

MR. VAN LIGTEN: Yes.

MR. MISHKIND: There's no answer required.

Q. What is your experience in terms of long-term outcome for these patients?

A. Again, we are speaking about recurrent corneal erosions?

Q. Yes.

A. I think I sort of addressed that before, but I'll be happy to go over it again. I think it really depends on getting them on the right combination of ocular lubricants, and, like anything else in life -- in fact, I just saw a man within this past month who came in, let's say, for the fourth or fifth time in two or three months with the same symptoms of recurrent corneal erosion, and I said, "Well, are you using your ointment in your eye at night?" "No, I stopped it because my eyes started feeling better, so I haven't been using it."

So the point is compliance is an issue, obviously, so if you don't take your

medicine, you're not going to get the effect of the medicine. It's as simple as that. I'm just kind of giving you that as an aside. I think you're referring to it under optimal circumstances.

Q. Right.

A. If you or I had a recurrent corneal erosion, you know, I think we would have a good response to treatment. I'm not saying we would necessarily be cured, but I think we would be informed as to what the problem was and what could be done for it when it occurred.

Q. Once you have that basement membrane problem, that's a life-long condition that will not ever return to its previous or normal state?

A. That's my understanding of the -- and personal experience, yes.

Q. I think we've pretty much beat recurrent corneal erosion syndrome.

The second diagnosis you have made is functional visual loss. Could you please give me a definition for that.

A. Functional visual loss is a condition where visual acuity and/or visual field is abnormal with no underlying organic lesion to

explain that response. That's probably as simple as I can make it.

Q. So what is the cause?

A. Well --

MR. MISHKIND: Are you talking about in general or specific to this case, in his opinion?

MR. VAN LIGTEN: Let's say in general.

MR. MISHKIND: Okay.

Q. If there's no organic lesion, what's causing the decreased visual function?

MR. MISHKIND: Again, you're speaking in general?

MR. VAN LIGTEN: In general, yes.

A. If we are going to speak generally, then we might as well cover the whole topic, I think. I divide nonorganic or functional visual loss, and I'm using those terms synonymously, into two categories; malingering or, let's call it, hysterical visual loss. And the difference is a person who is malingering is consciously feigning visual disability for some gain, usually financial. The other form has been looked at -- has not been well looked at from a psychiatric or

psychological standpoint, and it's not understood why some people will develop this hysterical form of visual loss, but it's extremely common after injuries to the eye. And as to why that is, I don't think anyone in the world can tell you.

So I look at functional visual loss of the nonmalingering sort as essentially a psychological problem very much akin to hysterical paralysis, for example. The problem is there's not a whole lot of literature on it. And, for some reason, psychiatrists and psychologists are not really interested in studying it. I don't know why that is, but in terms of my scheme of dealing with it, that's how I look at it, and that's what the literature states, basically.

However, in those rare studies that I've actually looked at, things like the MMPI, the Minnesota Multiphasic Personal Inventory, they don't really show any severe psychopathology, so it's not like it's a warning sign of schizophrenia or manic depressive illness or anything like this.

Q. How do you make this diagnosis? Is it one that you rule out everything else?

A. Correct. It's a diagnosis of exclusion.

Q. Let's now focus on Mrs. Savage. How did you determine that that was the diagnosis in her case?

A. Well, I think from the -- from really what we have gone through already, but we might as well list them.

Subnormal visual acuity with a difference between distance and near. A person 20/200 at distance should be a near equivalent of 20/200 if it's organic, meaning if there's a lesion causing it. That was one red flag for me.

Number one was the fact that her eye exam was completely normal and she did not have any evidence of an afferent pupillary defect, which we discussed.

Number three was the variability in her visual fields which had no organic explanation.

And then, of course, we have talked about other things, such as a normal MRI and normal fluoroscein angiogram, et cetera, et cetera. That's further documentation that behind

the eye the optic nerve was not damaged by a tumor or something like this.

Q. Have you had patients in your practice with the diagnosis of functional visual loss before, sir?

A. Yes. Yes, I have.

MR. MISHKIND: Off the record.

(Discussion off the record.)

Q. And what is your experience in terms of their, I guess, their prognosis?

A. It's really variable, and the only thing in the literature and, also, I could echo that with my personal experience, that seems to have any positive effect is reassurance in the sense that what you say is essentially we have excluded anything real serious in your case, and, you know, we are certain that you can get better, your vision can come back; we just don't know the time frame. It may be tomorrow, it may be a week, it may be a month.

And the people who are receptive to that will get better, and the people who are not receptive to that, and I don't mean that in a volitional way, won't. And it's just one of those things we don't have a handle on. It's

kind of like trying to pick up a drop of mercury, functional visual loss. It's very difficult to pin it down from a scientific standpoint.

Q. Of the people with this diagnosis, how many do return to their previous function?

A. I think that's a question that could be answered in two ways. One is how they act or how they measure, and let me tell you what I'm getting at. I've seen people with functional visual loss who, when you see them in the office, they measure still having a visual disability, but yet from a functional standpoint, meaning in their daily lives, they're doing better from their perspective. And I've also seen people who, you know, are always disabled, so to speak, or symptomatic, symptomatic for their condition. And, again, I can't tell you what separates those two groups of people.

Q. Is it your experience that the majority get better, or do the majority stay impaired?

A. I would say that the majority stay impaired.

Q. In your practice, besides reassurance, do you provide any other referrals or

recommendations to psychiatric or psychological care, sir?

A. Unfortunately not, sir, because there's no documentation that that helps. I wish it did, because that would -- it's one of these things that many neuro-ophthalmologists just hate to see because it's so frustrating. It's a condition where you spend a whole lot of time. You spend probably more time in a person with functional visual loss than with some other easily identified entities because you have to go through everything to make sure you're not missing something, if you understand what I mean. And then you come up with this, you know, there's no organic cause for it and the treatment is a reassurance and the prognosis is not good.

So it's a difficult thing for some guys to handle in that sense. But, fortunately, it's not a common event in the sense of we don't see one every day or whatever, but it's a common neuro-ophthalmology referral problem.

Q. In your practice, how often would you have a patient with functional visual loss come back to your office for reexaminations?

A. I would probably say three months

initially for a couple of visits and then, you know, increase the interval from there. The reason for that would be if I saw someone back in three months and they are better objectively, then I would really hit them with the reassurance again saying you're doing great, this is fabulous. I would coach them; you know what I'm saying? So I would do that rather short interval initially to see if I got a positive effect. Then I would, you know, up the reassurance part of it.

Q. So you do it for three months for a couple of times, and then go to six months or --

A. Yeah. You know, I'm just giving you a ballpark. I've never even thought about that question before, but I would say that would be something that would be something that I would do probably. Oftentimes I'll ask the patient and say when would you like to come back, you know, and that's often a good barometer because it tells you a little bit about where they stand with regard to their anxiety level about the condition.

Q. Do you ever discharge these patients from your practice and say we've had maximal

benefit from my intervention, or do you continue to see these people on an annual basis or --

A. Well, again, ideally, in a normal ophthalmology practice it's a referral practice, so you try to get the patients back to the doctor that initially referred them to you. And that sometimes can be done with functional patients and sometimes can't because sometimes the doctors who refer them to you really don't want them back for the reasons we've just talked about. So in that case I would follow them. I would become their primary ophthalmologist, I would have no trouble with that. But, again, that's an individualized sort of thing.

Q. If Judith Savage was your patient, how much would you, at a minimum, be seeing her?

A. Again, I saw her only once back in March of 98. I would have probably seen her three or four months later and then taken it from there.

Q. Say you have a patient -- let me try and hypothesize this -- such as Judith Savage who has had, again, hypothetically, no improvement in a five-year period. How often would you see her for the remainder of her life?

MR. MISHKIND: Before you answer, let me just object only because it's only been three years, so the hypothetical does not contain facts consistent with this case, but it's a five-year interval in your hypothetical and he can go ahead and answer it.

A. I would say yearly.

Q. I'm just trying to get an idea of what Judith is looking at in terms of long-term care.

A. Sure.

Q. It would be your expectation that she sees an ophthalmologist on an annual basis at a minimum?

A. For the functional visual loss aspect?

Q. Yes.

A. Then the corneal erosion aspect is obviously another issue.

Q. It just seems surprising to me that there isn't medical trials with Paxil or one of these newer agents to see if they would help.

Are you aware of any medical research --

A. No.

Q. -- trying to aggressively treat this

entity of functional visual loss?

A. No, I'm not.

Q. Since you raised the issue, and I guess I should cover it to be complete, in terms of what your recommendation or expectation would be in terms of the recurrent corneal erosion syndrome, how often do you think a patient with that condition needs to be seen on an ongoing chronic basis?

A. It would be totally driven by her symptoms. So, in other words, if she was asymptomatic, depending on the age, in ophthalmology, we have certain general guidelines about what happens to you at different ages and when you should be seen, but, you know, a year to two, whatever, in that general time frame, if she was asymptomatic.

Q. In terms of the entity she has now, have you formed an opinion as to what caused that?

A. Yes, I have.

Q. Can you tell me what your opinion is, sir?

A. We're dealing with two issues that are related. Can we go through them one at a time?

Q. Absolutely.

A. Which issue would you like to start with?

Q. With the recurrent corneal erosion syndrome.

A. Well, we have documentation that Mrs. Savage had corneal trauma, if we define trauma as an abnormality in her corneal epithelium leading to a corneal abrasion during her hospitalization. And that is sufficient to cause a recurrent corneal erosion syndrome.

And, secondly, we have the functional visual disturbance which I think I indicated earlier often follows trauma, eye trauma. So in that regard, I think they're related.

Q. From your review of the materials that you were given and your examination, can you form an opinion as to what caused the trauma?

A. Yeah. I can form an opinion.

Q. Let me just lay --

MR. MISHKIND: To a reasonable degree of medical probability.

A. Yes, of course. My understanding, after reviewing the records, is that when Mrs. Savage awoke from anesthesia, having had her

carotid gland on the right operated on and the facial nerve dissected partially, that she complained very shortly thereafter of some irritation in her right eye. And, subsequently, a few hours later, an ophthalmologist examined her and diagnosed a corneal abrasion, and as part of his note -- or corneal -- let me just see what he actually said. Corneal abrasion. And his conclusion was that it was probably secondary to exposure, possibly secondary to trauma.

So, given those facts, my opinion is that this corneal problem originated during the surgical procedure.

Q. Let me interject that if a nurse had witnessed the patient rubbing her eyes repeatedly in the post-anesthesia period, would that change your opinion, sir?

MR. MISHKIND: Let me just object for several reasons. The testimony is inconsistent between the nurses as to the observations, and certainly inconsistent with what's in the records. But if you're basing it just solely on that hypothetical, he can go ahead and answer the question.

Q. You can take this as a hypothetical.

If there is testimony that, prior to Mrs. Savage complaining of severe eye pain, she was noticed by a nurse to be rubbing her eyes repeatedly, would that change your opinion?

MR. MISHKIND: Let me show an objection to the hypothetical, but go ahead and answer the question, if you can.

A. I think what you're asking is could she have caused her own corneal abrasion.

Q. Yes.

A. It's a possibility, under those hypothetical terms.

Q. I'm just going to ask some general housekeeping kind of questions while I try and kickstart my brain here a little bit.

I take it you're licensed in the State of Ohio?

A. Yes.

Q. Has your license ever been suspended, revoked or limited in any way, sir?

A. Well, I had a problem in 1989. Actually, I had a problem with alcohol and went away for 30 days in 1984, and then in 1989 the Ohio State Medical Board said that I didn't tell them that I had gone away for treatment and they

suspended my license for a month, but this didn't involve any sort of patient care issues, and I've had no problems in that regard since.

Q. Have your privileges at any hospitals, aside from the hospital going bankrupt, been restricted, revoked or limited or denied?

A. Only administratively during that one month.

Q. That would be in 1989?

A. Correct.

Q. Do you hold licensure in any other states, sir?

A. No, I don't.

Q. Have you ever been convicted of any felonies?

A. No.

Q. In terms of your time spent doing this expert witness work, how much do you charge for that?

A. For review of records and meetings with attorneys, $250 an hour. For depositions, $500, and then in-court testimony would be negotiable depending on the situation.

Q. Is that based on hourly, or how do you base your fees for trial testimony?

A. Well, it would -- I would have to decide how much time I would have to take off work, travel, et cetera, et cetera, so that's what I meant by negotiable in terms of the time put in.

MR. VAN LIGTEN: If we could take a minute, Howard.

(Recess had.)

Q. Are there any other entities that involve the basement membrane and cornea, any other medical entities, that could cause similar symptoms aside from recurrent corneal erosive syndrome?

A. I'm not sure I really -- I understand your question, but I don't really -- you're asking about other basement membrane problems that do not cause corneal erosion syndrome, sir?

Q. Let me rephrase that. If someone comes into your office with complaints of recurrent pain of the cornea or, I guess, recurrent eye pain which symptomatically sounds a lot like recurrent corneal erosive syndrome, and your evaluation initially would include a differential diagnosis in addition to corneal erosive syndrome, what would be on that list of

differential diagnoses?

A. Well, I guess the other big one would be what we call dry eye syndrome where the -- it's not just tear production, but it's the quality of the tears is abnormal and essentially leads to the same symptoms, but, again, the treatment is the same, would be the same, as for corneal erosion syndrome.

Q. Are there any ocular conditions related to patients with thyroid disease?

A. Are there any ocular conditions related to thyroid?

Q. Yes.

A. Yes, there are. There are a whole number.

Q. Are there any other disease processes that would mimic or be similar to recurrent corneal erosive syndrome in patients with thyroid disorders?

A. Only secondarily to exposure or tear forming ability. In other words, the pathophysiology of the cornea would be the same, but the cause for the corneal problem would be the abnormal blinking or abnormal tear production in the thyroid eye disease.

Q. Do you know what caused Mrs. Savage's thyroid problem?

A. No, I don't.

Q. Are there some autoimmune disorders of the eye that could mimic corneal erosive syndrome?

A. Sjogren's syndrome would be the big one, I suppose.

Q. Is there some association in terms of the incidence with Sjogren's and thyroid disease, sir?

A. I bet there is, but I don't know the statistic.

Q. As far as you know, are there any medications which may cause symptoms similar to recurrent corneal erosive syndrome?

A. Well, there are numerous medications that can cause the dry eye syndrome, and, really, they're all over the ballpark. But we usually think of them as the medications that have some sort of an anticholinergic effect, therefore, decreasing tear production, but I would bet if we looked it up in the books, just about any medication -- not just about any, but there would be more than we would expect to find that have

been associated with dry eye problems.

Q. Do anesthetic agents fit in that category?

A. I'm sure they do, but, again, one would expect their actions to be limited to the time which they were given and metabolized by the body.

Q. As far as you know, was Mrs. Savage on any medications which may have caused symptoms similar to recurrent corneal erosive syndrome?

A. I don't have that in my notes, so I can't say whether she was or wasn't. Although I would like to just add on that most of the time those symptoms are bilateral in dry eye, in thyroid, et cetera, in medicational-related dry eye, so here we have a person with unilateral symptoms, basically.

MR. VAN LIGTEN: I'm done.

MR. MISHKIND: We'll reserve signature.

- - - - -

(Deposition concluded at 11:30 o'clock a.m.)

(Signature not waived.)

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AFFIDAVIT

I have read the foregoing transcript from page 1 through 52 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

_____

ROBERT L. TOMSAK, M.D., Ph.D.

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

_____

Notary Public

My commission expires _____.

CERTIFICATE

State of Ohio,)
) SS:
County of Cuyahoga.)

I, Karen M. Patterson, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named ROBERT L. TOMSAK, M.D., Ph.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 13th day of July 2000.

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

My commission expires October 7, 2004.

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