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

IN THE COURT OF COMMON PLEAS

AMY DIETZ, et al., )
) Case No. CV-2014-01-0124
Plaintiffs, )
)
vs. )
)
AKRON CHILDREN'S )
HOSPITAL, et al.,
)
Defendants. )

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THE DEPOSITION OF PETER LETOURNEAU, M.D.
February 4th, 2014

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The deposition of PETER LETOURNEAU, M.D., called by the Plaintiffs for examination pursuant to the Ohio Rules of Civil Procedure, taken before me, the undersigned, Kelly A. Hill, Notary Public within and for the State of Ohio, taken at Akron Children's Hospital, 215 West Bowery Street, Akron, Ohio, commencing at 2:00 p.m., the day and date above set forth.

APPEARANCES:

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PETER LETOURNEAU, 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 PETER LETOURNEAU

BY MR. DICELLO:

Q Good afternoon, Doctor.

A Howdy.

Q Could you please start by saying your name and spelling your last name for Kelly?

A Peter Robert Letourneau, L E T O U R N E A U.

Q Doctor, my name is Nick DiCello. We had a chance to meet off the record briefly. You understand I represent Makenzie Dietz and her parents in connection with a lawsuit that's been filed against Dr. Jones and Akron Children's Hospital?

A Correct.

Q You understand today's my opportunity to ask you questions under oath in what's called a deposition?

A Yes.

Q Have you ever had your deposition taken before?

A No.

Q Okay. I'm sure --

A And just so you know, I'm on call. So if I get paged or --

Q Do whatever you need to do, okay?

A Okay.

Q I'm sure Mr. Rossi has told you kind of how the process works, but while we're talking about it, let me just state some ground rules.

If you answer a question I've asked, I'm going to assume you've understood it.

Is that fair?

A Yes.

Q And if you don't understand a question that I've asked, just let me know. I may have garbled it, said something that's not coherent, which I sometimes do; so just let me know that, okay?

A Okay.

Q We have to make sure that we don't speak over one another - you're doing a nice job of that right now - so Kelly can take everything down, okay?

A Okay.

Q And you're also verbalizing your answers, which I'll remind you to do from time to time if you just give a shrug of the shoulder or a um-hum

or hu-hum. It's better to answer with words, yes, no --

A Sir, yes, sir.

Q Great.

If you don't remember something, that's a perfectly fine answer; I don't recall, I don't remember.

If at any point during the deposition - it's not uncommon that your memory is jogged about something - you want to revisit a question I asked or an answer you've given, I want you to take the opportunity to do that, okay?

A Yes.

Q Doctor, why don't you go ahead and start by just maybe explaining a little bit about your practice and position here at Akron Children's Hospital?

A I'm a pediatric plastic surgeon at Akron Children's Hospital.

Q How long have you been a pediatric plastic surgeon here at Akron Children's?

A Four and a half years.

Q Where are we located today, this office?

A 215 West Bowery Street, Considine Building,

Suite 3300 in the plastic surgery conference room.

Q Is this where you have an office-based practice?

A Next door, yeah.

Q In this -- this office, this floor?

A Yes. And I also have an office-based practice in Youngstown.

Q Are you employed by Akron Children's Hospital?

A Yes.

Q How long have you been employed by Akron Children's Hospital?

A Four and a half years.

Q You told me you're a pediatric plastic surgeon. Do you have any other titles here at Akron Children's?

A I'm sure people call me other things, but --

Q I think I saw you were a co-director of --

A Brachial plexus clinic, yes.

Q Anything else that comes to mind in terms of a formal title?

A Maybe some upper extremity thing. I can't remember what they -- the PR people like to label.

Q I'm not going to go into much of your

background, Doctor, and I'm going to be as quick as I can with you today, but you've been working here for about four and a half years. Can you just tell me where you were before you came to Akron Children's?

A I did my plastic surgery training, and then did a microsurgery fellowship at University of Pittsburgh. Then did a pediatric plastic surgery fellowship at Cincinnati Children's and then I came here.

Q And where did you attend medical school?

A University of Rochester in Rochester, New York.

Q When did you graduate from medical school?

A 2002.

Q Plastic surgery, can you just kind of define that discipline for me?

A Difficult. It's a hodgepodge of lots of things that could be cosmetic surgery, it could be boob jobs and tummy tucks, it could be Dr. 90210.

Traditionally plastic surgery was reconstructive surgery to try to fix things that were broken, and it can include hand surgery, microsurgery, nerve surgery, lesion removal, fractures of the hand.

Q I should be able to put the math together, but let me ask you: As of December of 2010, how long had you been working at Akron Children's as a plastic surgeon?
A Almost six months. I started August 1st.
Q Okay. Let's start as of that time.
As of the time you started, can you explain your practice a little bit in terms of the prevalence of the kinds of procedures, or if you had a particular focus, however you would explain it?
A My focus is on upper extremity, like hand surgery, brachial plexus palsies, which are not that common, so I don't do a lot of that, trauma, and I do a lot of lesion excision.
Q Is the practice you've just described true as of today and also as of December of 2010?
A Well, it's expanded. I mean, I started off and I was not super busy as you typically are in your first six months to a year of practice. So I'm certainly a lot busier now. But I would say the scope and focus of the practice has stayed the same.
Q Okay. How many days a week now do you perform surgical procedures?

A It totally depends. I mean, my priority day is Friday, so I operate almost every Friday. But I often end up operating on Monday and Thursday, as well as Friday, and then I take call, so sometimes I'm operating on weekends.

I would say it's anywhere between two and four days a week, but it depends.

Q So as of December of 2010, it was probably a little bit lighter schedule than that?

A I don't recall.

Q Okay. And with respect to surgical procedures on nerves, is there any way you can quantify what percentage of your surgical practice encompasses surgeries on -- on nerve structures?

A Without having numbers in front of me, not really. I mean, small compared to the overall volume of the practice just because nerve injuries are relatively uncommon.

Q When you say small, I'm not asking you for a specific number, but are you able to approximate any kind of percentage, less than five percent, twenty percent? Can you say?

A (Witness shakes head side to side.)

Q No?

A No.
Q Okay. Fair enough.
Doctor, what, if anything, did you do to prepare for today's deposition?
A I read over my notes for this -- related to this child. It included pre-op, post-op, intra-op, and I read over Dr. Jones' deposition.
Q We also have some photos and a disk that you were kind enough to put out for Greg and I to look at, and I'm going to go through those with you.
A And I reviewed those photographs.
Q And my question now is: With respect to these photos and this disk which we will get to more specifically, where did you retrieve those from?
A From my computer.
Q Do you have any other files related to Makenzie Dietz on your computer other than the disk and the photos?
A Not to my knowledge.
Q And before we started your deposition, you said you were going to go into your office and retrieve a stack of stuff. Is that any stuff

that's related to Makenzie Dietz or this case?

MR. ROSSI: It's the deposition and it's a copy of his records. That's all.

Q So what depositions, if any, did you review prior to today?

A The only one I'm aware of is the one where you deposed Dr. Jones.

Q And did you read that?

A And that's the one that I read.

Q Okay. Okay. Great.

Prior to today's deposition, have you spoken with Dr. Jones about the patient or about this case since the time Makenzie stopped treating with you?

A Well, we share a clinic on Wednesdays two or three times a month, so I don't recall any specific conversations, but I know that we would kind of update each other on mutual patients, and he had told me that she was doing well.

And then when I heard that I was going to be deposed in this case, I called Dr. Jones to let him know and he said, Well, we're not really supposed to talk about it, but just be honest. And that was the end of that

conversation.
Q The procedure that Makenzie had -- one of the procedures she had that Dr. Jones performed was an inside out lateral meniscus repair arthroscopically; is that correct?
A I don't know. I'm not an orthopedic surgeon. If that's what it says in the operative report, I have to accept that.
Q That was going to kind of be my next question; have you ever performed any kind of arthroscopic meniscal repairs --
A No.
Q -- as a surgeon?
A No.
MR. ROSSI: You're doing well, but let him completely finish his question before you answer.
Q That's fine. Everybody does it. You know what I'm asking. You just have to wait.
So including in residency or your training, you never participated in any arthroscopic knee procedures?
A No.
Q The procedure that you participated in took place on December 23rd, 2010, correct?

A Yes.
Q And correct me if I'm not describing it properly, but it was a procedure to explore a potential nerve injury based on the patient's clinical presentation, correct?
A Yes.
Q And it was also a procedure to attempt a nerve conduit repair, correct?
A We did perform a nerve conduit repair.
Q Other than Makenzie, had you ever performed a similar surgery on a knee for a similar clinical presentation in a patient?
A No.
Q So Makenzie Dietz was the first time you had explored a peroneal nerve injury of a knee after an knee arthroscopy?
A Yes.
Q Have you done any such procedures since, that is explore a peroneal nerve injury after a knee arthroscopy in a patient?
A No.
Q Obviously, Doctor, you know I've had the chance to depose Dr. Jones and I've been through the records, so I'm going to try to move through this. I might jump around. Just let me know

if you don't understand what I'm talking about or the subject matter.

A Okay.

Q It's my understanding at some point in 2010 Dr. Jones consulted you --

A Yes.

Q -- about this patient, correct?

A Yes.

Q As you sit here today, do you have a recollection of that independent from your review of the medical records?

A I remember him talking to me about it. I don't remember when it was, but, yes.

Q Was this a face-to-face conversation or over the phone?

A Face-to-face.

Q Do you remember the substance of the conversation at all, what he said and what you said?

A I think the question was timing of exploration if exploration were to be performed.

Q Let me ask, if maybe just out of curiosity: Why is it that you would be the surgeon consulted to perform an exploratory procedure like the one that was done on Makenzie in

December of 2010?
A Orthopedic surgeons typically don't operate on nerves.
Q And you do?
A Yes.
Q Prior to the December 23rd, 2010 procedure, had you ever operated on a patient of Dr. Jones before?
MR. ROSSI: Objection.
Q Obviously without disclosing names, Doctor.
MR. ROSSI: Go ahead. You may answer.
A I don't know. I know that he and I have performed multiple co-surgeries.
Q Okay.
A As to the timing of those, I -- I honestly don't know.
Q That's kind of where I was getting at is: When you say co-surgeries, you mean the both of you were surgeons involved in the case, correct?
A Yes.
Q At the same time?
A Yes.
Q Can you estimate for me how many times you've done that with Dr. Jones?

MR. ROSSI: Objection to relevance.

But go ahead. You may answer.

A Probably more than five and less than ten as an estimate.

Q And do you have any idea how many times you had done that as of December 2010? Do you know if it was the first time you had ever done a co-surgery with Dr. Jones?

A I don't know.

Q What was your understanding of the reason an exploratory procedure was being performed?

A Makenzie had a foot drop, which occurred after her arthroscopic surgery of that knee and -- and nerve conduction study had showed that there was no conduction across the area, and so we wanted to see what was going on.

Q Did you actually perform a physical examination of the patient before the December 2010 procedure, if you remember?

A I did. I saw her on December 15th and I examined her.

Q Okay. At that time, on December 15th, did you have -- whether you documented it in your note or by habit or practice or by memory, did you

have, in your mind, a differential diagnosis as to what the possibilities were that were causing Makenzie's foot drop?

A Well, I always have a differential diagnosis in mind if I'm going to operate.

Q What was the differential in your mind on December 15th, 2010?

MR. ROSSI: You're welcome -- you can look at your notes. It's not a memory test.

A I was concerned that there was potential nerve injury that had not shown signs of recovery.

Q In terms of a mechanism associated with the potential nerve injury, had you come to form any kind of differential diagnosis with respect to the mechanism of injury?

MR. ROSSI: On December 15th?

MR. DICELLO: Yes.

MR. ROSSI: Go ahead. You may answer.

A No. I am not familiar with knee arthroscopic surgery, the inside out procedure or any of that. So really, I didn't know.

Q Okay. Do you perform surgeries where part of your job as the surgeon is to try to protect

neurovascular structures?
A Well, when I operate around nerve vascular structures I try to protect them.
Q And is one of the ways you do that by visualizing the nerve and retracting it away? Is that one way to do it?
MR. ROSSI: Objection.
Go ahead. You may answer.
A That is one way to do it.
Q And is some of the other way -- another way to do it is identify certain landmarks and retract those landmarks away?
A Yes.
Q Is it important for a surgeon to protect neurovascular structures surrounding the area where the surgery is being performed?
A Yes.
Q Why is that important?
A Because you don't want to injure them.
Q So what I'd like to do is maybe go through the operative note and maybe we can use these photos as well as we're going through. And I want to have you explain some things.
I have an extra copy of it. I'm going to actually mark this as an exhibit. You can use

whatever copy you'd like.

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(Thereupon, Deposition Exhibit 1 was marked for purposes of identification.)

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Q So just for purposes of the record, Doctor, I'm handing you what's been marked as Plaintiff's Exhibit 1 of your deposition.

Can you confirm that's the operative report from December 10, 2010?

A It is.

Q A couple housekeeping issues; did you dictate that note, if you remember?

A I did.

Q And, obviously, both you -- well, both you and Dr. Jones signed this note, correct?

A Yes. So officially -- this is a confusing point as far as medical records goes. Nowadays I don't think he would have to co-sign it, but, basically, the medical records people, when it was on paper, if they saw any attending surgeon's name on an operative report, even if they were an assistant or otherwise, they would flag it, and so you would have a ten-foot stack of things that you had to go through and

initial.

Q But just to -- so I understand, you're the one that dictated this note, you signed it and then Dr. Jones signed it?

A Right. I was the primary surgeon on the case.

Q Okay. Did you have any conversations with Dr. Jones about the content of this report before either you or he signed it?

A No.

Q Do you know how it is that Dr. Jones was provided a copy that he then affixed his signature to?

A As I said, in medical records, they -- their habit was to flag any operative report that had any attending surgeon's name on it and put a little sticky thing color coordinated, and you had to go by and initial it or you got on the bad boy list.

Q Okay. Understood.

I want to go through some portions of this operative note. In the first paragraph, you indicate that Makenzie woke up with a peroneal nerve palsy. Was that your understanding of the circumstances surrounding her original surgical procedure?

A I know that's what it says here. I don't know specifically, since I didn't review in detail Dr. Jones' operative report -- his initial operative report, how he does it and whether or not they're immobilized afterwards. So whether she woke up in recovery and had a foot drop or it was noted two weeks later, I honestly don't know.

This was just kind of a gestalt.

Q And I should ask you before we get too far into the note, do -- as you sit here today, do you recall this surgery?

A Yes.

Q So you have a memory, independent of the medical record, of this particular procedure?

A Yes.

Q You do document in the first paragraph, again, that you had an extensive discussion with Dr. Jones. It says, after extensive discussion with Dr. Jones and the family, we decided that exploration would be prudent.

Do you recall having that discussion with the family and Dr. Jones before the surgery?

A No.

Q Now moving on to the description of the

operative procedure, Doctor, it sounds to me that Dr. Jones performed the incision, correct?

A I believe I marked out the area because I was going to extend the incision because it was too small to be able to identify what we needed to identify.

And then who actually made the incision, I don't know. It was probably me, but I don't actually recall.

I do know that because I don't operate on the knee on a frequent basis, that Dr. Jones did the initial dissection once we got through the skin to get down to the area of where his inside out surgery was and then we identified the peroneal nerve together, and then I took over the rest of the case and he assisted.

Q In your answer you just said something to the effect of the original incision. I presume you're talking about Makenzie's incision that she had back in August for the original arthroscopy?

A Yes. She had multiple -- typically with arthroscopy you have more than one incision.

There was a lateral incision in the -- well, there was a lateral incision, and that's

the area that we decided to explore, and that incision had to be extended.

Q You said the original incision was too small to identify what you needed to identify. What did you mean by that?

A I don't know. I wanted to have enough room to be able to retract and look.

Q Okay. So was it your decision then to extend the incision, was that a joint decision or do you not recall?

A Honestly, I don't recall. I mean, oftentimes I will mark out an incision. I don't make the entire incision until I've made the decision that I actually need to do something.

So whether or not I marked out the zig zag incision and we made that right at the beginning versus a small incision that we then dissected down, identified the injury and then extended it is equally likely. I have no idea.

Q Okay. So focusing back on the report that you described this, but it reads, Beginning of the procedure was conducted by Dr. Jones who dissected down to the level of the biceps tendon. This was retracted anteriorly and the peroneal nerve was identified.

My first question is: During this part of the procedure, do you remember where you were positioned relative to Dr. Jones?

A Probably right next to him.

Q And so were you able to grossly visualize what you're describing in the report that I just read?

A Yes.

Q So at this point you weren't using any kind of loop magnification or anything?

A I always use loop magnification. I had probably 3.2 loops on.

Q The whole procedure?

A (Witness nods head up and down.)

Q Yes?

A Yes.

Q Okay. Was Dr. Jones, to your knowledge, wearing -- to your memory, was he wearing those loops as well during this part of the procedure where the dissection was taken down to the level of the biceps tendon?

A I don't recall.

Q Based on your memory, or according to the report, were both of you able to visualize the biceps tendon and visualize it being retracted

anteriorly?
A I don't know that I can speak for Dr. Jones. I know that I identified the biceps tendon. He probably had to tell me that that was the biceps tendon because I don't routinely go in there. I don't know.
Q In terms of who was holding the retractor blades, do you know who was doing that?
A No. This was a very fluid procedure.
Q And then it says the peroneal nerve was identified. Did the both of you identify that?
A Yes, I believe so.
Q And you told me you were wearing loops at this point in time; did you need those loops to be able to identify that peroneal nerve?
A No. The peroneal nerve is probably -- in her was at least a diameter of a number 2 pencil.
So, no, you don't need loops to identify it.
Q Both you and Dr. Jones identified the peroneal nerve at that point, correct?
A I believe so, yes.
Q And then it says, At this point I took over the dissection.
So once the peroneal nerve was identified

and the biceps tendon was retracted, then you took over the case, correct?

A Yes.

Q It then says, I released some fibers of the biceps tendon longitudinally in a parallel direction with fibers proximally to allow better visualization.

Can you just explain to me what you were doing there; what that means?

A Well, the biceps tendon kind of inserts right on top of the -- a portion of the peroneal nerve. So we released a little bit of the tendon so that I could visualize the nerve better.

Q When you say released, what do you mean?

A Incise.

Q Reading on it says, Under loop magnification, I then dissected the peroneal nerve distally and proximally, sacrificing some small muscle fibers of the biceps.

First, did I read that correct?

A Yes.

Q Can you explain to me what you're doing here? Is this pulling the peroneal nerve away from the muscle tissue?

A Well, typically you don't want to pull on a nerve. So, no, I was getting rid of some small muscle fibers of the biceps to expose the nerve where it's supposed to be.
Q Okay. My question is: Was that -- that portion of the nerve that you're describing in the sentence I just referenced, was it embedded within the musculature or was it attached to the musculature? How would you describe --
A I don't recall. I just remember it was underneath.
Q When you say you dissected, was this blunt dissection or sharp dissection; do you remember?
A Typically blunt until I -- yeah, typically blunt.
Q Okay. So when I said pulling the peroneal nerve, that was a poor choice of words, but you were actually bluntly dissecting it off the muscle; is that fair?
A I don't know that it was adherent to the muscle. It was just -- I mean, there are multiple tissue planes and you dissect through tissue planes to get to what you want to see.
Q Okay.

A And so whether it was -- whether I separated it from the muscle or I separated it from the subcutaneous fat, I don't know. I just dissected out the nerve.

Q Up to this point in time where we're at -- first of all, does your operative note document any kind of anatomical variance that this particular patient had with respect to her peroneal nerve?

A No.

Q Based on your memory of the case and having the opportunity to look at the operative note, Doctor, did you encounter any kind of anatomical variance or deviation with respect to Makenzie Dietz' peroneal nerve?

A I don't know. I've never dissected out a peroneal nerve before, so I'm not qualified to comment on that.

Q Reading on it says, Right at the level of the prior incision there was a quite noticeable narrowing of the peroneal nerve.

I'll take this in bits.

Is that the injured portion of the nerve ultimately, Doctor?

A Yes.

Q And when you say, right at the level of the prior incision, it sounds obvious what it means, but now that I have you here, can you explain what that means?
A Well, it was not in the incision, because the incision would imply the skin, but it was deep to that.
Q But it was within the area of the original incision, not the extended incision, correct?
A Correct.
Q Okay. On further exploration, there were multiple strands of what appears to be a reabsorbable monofilament suture that was in the body of and around the nerve.

Did I read that part of the operative note correctly?
A Yes.
Q Again, this is something you were able to visualize grossly wearing your loop magnifiers?
A Yes.
Q Had you ever seen that during a surgery, strands of suture embedded in and around a nerve?

MR. ROSSI: Objection.

Go ahead. You may answer.

A Not to my recollection.
Q And when you say multiple, is there any way for you to quantify that?
A No.
Q If it were -- if it were two, would you have said two? I mean, sometimes it would be if I saw two I'd say two; if it was more than two I'd say multiple. Anything help clarify that any more?
A Well, I think -- again, this is in retrospect; there were pieces. So you start to get into semantics of what's a strand, what's a piece.

I honestly don't know. I mean, I removed more than one piece. Whether it was part of the same suture or another suture, I don't know.

Q Okay. Reading on, Further dissection revealed a portion of the nerve that proximately was still attached to the main body of the nerve but was buried within the joint space.

First, did I read that correctly?

A You did.
Q And can you tell me what that means in terms of what you encountered during this procedure?
A Part of the nerve was kind of pulled towards

the joint space.
Q So my question is: Did part of the nerve fray away from the main body of the nerve and was adherent to the joint capsule?
A What do you mean by fray?
Q I guess in my mind I have this image of a singular nerve and a portion of that nerve kind of got pulled away from it and was close to the joint capsule as opposed to the whole nerve getting pulled toward the joint capsule.
So I'm trying to understand --
A Well, the nerve is like an electrical wire. So there's multiple filaments, and one portion of that was pulled towards the joint or joint capsule.
Q Was it still attached to the main body or was it actually -- was there actually space in between the part that was pulled toward the joint capsule?
A You mean was it severed?
Q Yeah. Yeah, I guess --
A It was not severed.
Q And when you say buried within the joint space, what do you mean by that?
A I don't really know. It was not -- I don't

operate on knee joints. It was -- we did not go into the knee joint. So it was, in retrospect, not buried within the joint space. I think it was adherent to the stuff overlying the joint.

We did not make an incision in the joint capsule to retrieve the nerve. So it was probably stuck to the capsule as opposed to stuck to the -- in the joint space.

Q Okay. The dissection portion of this procedure we're talking about on December 23rd, was dissection carried out down to the joint capsule?

A As I recall, yes.

Q And this portion of the nerve -- peroneal nerve that you described was adherent to the capsule, correct?

A Correct.

Q Adhered by sutures, true?

A I don't know. I mean, the -- it was stuck. So wherever there's been surgery there's scar. So whether it was stuck to the scar or stuck by suture, I don't know.

Q Okay. Reading on, you say, This was dissected free and additional remnants of suture were

encountered.

My question: When you say, This was dissected free, did you dissect that portion of the peroneal nerve that was adherent to the capsule from the capsule?

A Correct.

Q And when you did that, you encountered additional remnants of suture, correct?

A Yes.

Q Can you give me some idea, Doctor, after you dissect the peroneal nerve off of the capsule, you know, how far does it then move? Do you understand what I'm getting at?

If you said it was adhered to the capsule and then you dissected it away, can you give me some idea of how far it moves?

A I don't know. I mean, it goes back to where it looks like it's supposed to be, but I don't have a distance that I can give you.

Keep in mind I'm wearing loops; everything is magnified and hard to estimate.

Q Well, you did a nice job estimating the diameter of the nerve, but we'll get to that.

A Well, it's because I measured it.

Q So the sentence, This was dissected free and

additional remnants of suture were encountered.

The next sentence is, I measured what I thought to be the injured area of the nerve to be approximately two centimeters, correct?

A Right. So I had a ruler and I -- as you see in those photographs, I marked out what I thought was injured and then I measured out with a ruler.

Q And you identified injury based on the narrowing in part, correct?

A Yes.

Q And what other information caused you to estimate that the injured area of the nerve was approximately two centimeters?

A Well, grossly or under loop magnification or some point I had a microscope out, you can assess nerve as to whether it's healthy or not healthy.

Healthy nerve has a very characteristic color and kind of a glistening appearance. Unhealthy nerve has another very characteristic appearance.

Q Okay. And I think you then go on to describe that. You say, Distal to the narrowed portion of the nerve was obviously severely injured.

It was much yellow and fatty appearing than the proximal portion of the nerve above the injury. This suggested to me Wallerian degeneration of the nerve.

Did I read that correctly?

A Yes.

Q Did I say the word Wallerian correctly?

A You did.

Q And then you say, A decision was therefore made to excise the injured portion of the nerve and repair it. Given the fact that I anticipated the injured area to be two centimeters or less, I felt this could be performed successfully with a nerve conduit as opposed to harvesting sural nerve.

My question is: It's a little unclear to me the part about, I anticipated the injured area to be two centimeters or less. Did you believe before you went into the surgery that the injured area of the nerve would not be that long?

A No, I didn't have any expectations. The only reason why I documented the actual distance is that nerve gaps, which we then created artificially, can be successfully repaired if

the gap is two centimeters or less using a nerve tube.

So if it had been five centimeters, then I might have made a different decision.

Q Okay. That's helpful.

And then I'm paraphrasing here, Doctor, but follow along if I'm not getting this right. It looks like you're, for lack of a better term, kind of trying to find some good healthy margins on the portion you're excising, right?

A Correct.

Q And beyond the two centimeters, you had to excise another two to three millimeters beyond that to find those healthy portions of the nerve proximally and distally, correct?

A Yes.

Q You then measured the diameter of the nerve distally and proximally, which was approximately four millimeters, correct?

A Yes.

Q And that's -- goes back to this idea when you were explaining to me that this nerve -- this portion of the nerve is about the width of a number 2 pencil, correct?

A Yes.

Q Is that -- you may or may not have experience; is that pretty typical of the peroneal nerve in a child of her age in terms of width?
A I don't know what the typical diameter is.
Q And so a 4 millimeter Stryker nerve tube was used because that approximated the same size?
A Yes.
Q The portion of the excised nerve was sent off to pathology, correct?
A Yes.
Q And did you at some point receive and review a pathology report?
A I did.
Q The final diagnosis, according to the pathology report says, Right knee, exploration of peroneal nerve: large nerve with surrounding scar and foreign body giant cell reaction with polarizable fragments of foreign material.
Did I read that correctly?
A Yes, you did.
Q The pathologist describes this as a large nerve, correct?
A Yes.
Q Is that consistent with your visualization of the nerve?

A Yes.
Q Under the gross description of the specimen that was submitted to pathology, it describes it as 1.5 x .4 x .4 centimeters, correct?
A Yes.
Q And is that the area of the nerve that you excised that you believe to be injured?
A Yes.
Q And was that the portion of the nerve that was adhered to the capsule?
A I don't know that I can answer that. I mean, I -- it's the portion of the nerve that was injured.
Q Somewhere along this 1.5 centimeter length of this nerve, was that the part of the nerve that had the suture in it?
A Presumably. I mean, the path report says that there were sutures in it or polarizable fragments of foreign material, which I assume is referring to suture.
Q And somewhere along this 1.5 centimeter length was the part of the nerve that was actually adhered to the capsule, correct?
A Again, I don't -- one could make that assumption, but I don't -- I honestly don't

recall.

There's not a linear sequence of events where -- I mean, it's not something that I'm paying attention to when I operate. I'm just trying to fix stuff.

Q Okay. As you sit here today, do you have any opinion or understanding as to the mechanism by which the nerve was sutured?

A Only from reading Dr. Jones' deposition.

Q Back to this gross description when it describes it as 1.5 times .4 times .4 centimeters, am I correct that that's 1.5 centimeters long, .4 centimeters wide and .4 centimeter high?

A I think that's a safe assumption. It would be nice if they actually specified that, but everything contracts a little bit when you excise it, so an excised area of two centimeters may contract a little bit to 1.5 centimeters.

Q And that was going to be similar to my next question is: I think you described the injured portion of the nerve as being narrowed, correct?

A Correct.

Q And so assuming -- if we assume that the portion that you sent to pathology was the injured narrowed portion of the nerve, would .4 centimeters be a little narrower than the nerve otherwise would have been?

I think you see what I'm driving at. I'm trying to get an idea of how wide this lady's nerve was and it was described as narrowed and it's .4 centimeters width --

A I don't have a good answer to that.

I'm using a ruler that is graded in millimeters but not sub-graded into anything, and it's kind of a quick and dirty -- you know, what's the diameter that I need to -- that the nerve is going to fit into for a tube, whether it's 4.5 or 3.8.

Q Let me try it this way --

A I don't know.

Q Let me try it this way: You did document that this area of the injured portion of the nerve was noticeably narrowed, correct?

A Yes.

Q If that portion of the nerve was .4 centimeters wide, would you expect the healthy portions of the nerve to be a little bit wider than that?

A Presumably, yes.

And just reading this, it says approximately four millimeters. So it's not a measurement down to angstrom level.

Q I want to switch gears a little bit, Doctor.

I presume that the brachial plexus injury work you do is primarily nerve-related procedures, correct?

A Correct.

Q Those involve stretch injuries, rupture injuries, that kind of thing?

A Correct.

Q Do you have any -- and I'm sure there's some general guidelines or rules that you go by in terms of the sooner you get to an injured nerve the better chance of recovery, that kind of thing?

A Yes.

Q With respect to the mechanism here where the nerve is actually either encircled or entrapped or has been pierced by sutures, based on your experience, training, familiarity with nerve injury and performing surgeries to hopefully repair nerves, is there some kind of window of time within which if you get to that kind of

nerve and release it that it will more likely than not heal?

MR. ROSSI: Objection.

Go ahead. You may answer.

A So yes and no. The kind of accepted time period for -- so there is no time period for sensory recovery of a nerve.

You can reconstruct a nerve theoretically ten years down the road and eventually get sensory recovery.

There is a generally accepted time limit for motor recovery where the motor end plates, which are the satellite dish receptors on the muscle to accept the nerve stimulation of 18 to 24 months from the time of injury to get signal to those motor end plates. Otherwise they atrophy and then they don't recover.

Q In a situation like we have here where there's actually -- the nerve is demyelinated and there's Wallerian degeneration, are you aware of any kind of time window in which you have to release the nerve from being sutured or entrapped to prevent that from happening? Do you understand my question?

A It's the same time window.

MR. ROSSI: So what's the -- so it's clear on the record, what time window are you referencing?

THE WITNESS: Eighteen to twenty-four months.

MR. ROSSI: Thank you.

Q Are you aware of any medical literature that suggests that a peroneal nerve that has been entrapped by a suture will recover if released 18 to 24 months thereafter?

A I'm not sure I understand the question. Can you rephrase it?

Q I apologize. I'm not being clear.

Let's try it this way: When you encountered this nerve, you performed a nerve conduit repair, correct?

A Yes.

Q Did you at that time then, based on the appearance of the nerve, believe that just releasing it, just taking the sutures out, releasing it from being adhered to the capsule, was not going to result from recovery of the nerve, just that alone?

MR. ROSSI: You look confused. If you don't understand the question --

A I still don't understand.
Q I guess what I'm trying to get at is if you had any expectation that just by releasing the nerve off the nerve capsule and removing the fibers, that this nerve could potentially recover, you wouldn't have excised it and put in a nerve conduit, right?
A Correct.
Q So at the time you performed this procedure on December 23rd, 2010, you believed, based on the appearance of the nerve and based on your education, training and understanding of nerve injuries, that this nerve was not going to recover simply by being released off the joint capsule and removing the sutures, correct?
A Well, I think that in combination with a nerve conduction study that showed no conduction across the course of the peroneal nerve. I mean, that's -- you have to take it all together.

So if there's no conduction and there's obvious scar, then presumably it's not going to recover on its own.
Q Okay. Then let me maybe try my original question that I was trying to get at now that

we've gone through this.

Do you have any opinion or experience with respect to how long after the nerve is actually encircled or entrapped it would have to be released in order to recover on its own without the need for a conduit?

A I'm still confused. It seems hypothetical.

Q It is.

A So every situation of entrapment, encirclement could be different. It could catch a little bit of the nerve, could catch a lot of the nerve.

So I can't really -- the question that I think you want me to answer is you have 18 to 24 months before there's no chance of recovery, which is why typically you explore not four months before that window is gone, but earlier rather than later to try to make sure that you get recovery.

Q When you were being consulted on this patient by Dr. Jones, did he ever indicate to you that he was concerned that the nerve might be entrapped by sutures and that was the problem?

A No, I don't think that was ever discussed. I think he said, I'm concerned that there's a

nerve injury that happened after my surgery, so we need to find out what happened.

Q Let me ask you another hypothetical, Doctor.

If Dr. Jones had said to you, I'm concerned that this young woman has a nerve injury and I'm concerned that the nerve may be tethered to the joint capsule, would you have recommended exploratory surgery any sooner than you did?

MR. ROSSI: I'll object.

But go ahead.

A I don't know if I have an opinion one way or the other. Until I had this case, I didn't even know what that meant.

Q Until you had this case you had never heard of a peroneal nerve being tethered to a joint capsule during an arthroscopic procedure, correct?

A Correct.

Q Since Makenzie Dietz, have you ever heard of that happening?

MR. ROSSI: Objection.

Go ahead. You may answer.

A No, but I haven't researched. I mean, that's not part of my area of expertise to know how

often that happens or doesn't.
Q If it did happen here at Akron Children's, you would be one of the doctors who would be consulted, correct?
A Yes.
Q And have you been consulted on any other cases since Makenzie Dietz?
MR. ROSSI: Objection.
A No.

- - - - -

(Thereupon, Deposition Exhibit 2 was marked for purposes of identification.)

- - - - -

Q Handing you what's been marked as Plaintiff's Exhibit Number 2; Doctor, is that the disk that has the photos on it that we're about to go through?
A I have no idea. I made a copy of a disk that I gave to Greg --
MR. ROSSI: And I made a copy for you.
A -- which he made a copy.
So as to chain of custody and that particular disk you have in your hand, I don't have the slightest idea what's on it except it

has her name on it.

MR. ROSSI: So you know and it's on the record, it's for your future reference, he gave me a disk and I copied that disk to your disk, which you have marked as Exhibit 2.

And I just reviewed it before, and it looks to be all the photos that you have hard copies of.

A Sorry; I'm not trying to be difficult.

Q You're not being difficult at all, Doctor. This is the first time I'm seeing this stuff. I'm trying to sort it out.

- - - - -

(Thereupon, Deposition Exhibit 3 was marked for purposes of identification.)

- - - - -

Q Handing you what's been marked Plaintiff's Exhibit 3; that's a picture of Makenzie Dietz, correct?

A Yes.

Q Did you take that or did someone in your office take it?

A I took it.

Q Do you know what date this was taken?

A Not offhand.

Q Why did you take that photo?
A I sometimes take photographs of my patients to help me remember situations, surgeries.
Q Okay. And that's stored on your computer here at the office, the photo?
A No. It's stored on my computer at home.

- - - - -

(Thereupon, Deposition Exhibit 4 was marked for purposes of identification.)

- - - - -

Q Handing you what's been marked as Plaintiff's Exhibit 4; is this -- first of all, did you take this photo as well?
A I did.
Q And this is a photo of the incision on the posterolateral side of Makenzie's right knee, correct?
A Yes.
Q Do you remember when you took this one?
A This was December 23rd, 2010 at the very beginning of that surgery.
Q This photo depicts the original incision performed in August of 2010, correct?
A Well, it's the scar from the original incision -- one of the original incisions. You can see

another one here. I don't know where all the other ones are.

Q Either by looking at this photo or based on your memory of the case, can you approximate what the length of the original incision was?

A No, not without a ruler next to it.

- - - - -

(Thereupon, Deposition Exhibit 5 was marked for purposes of identification.)

- - - - -

Q Handing you Exhibit 5, Doctor; just for the record, can you identify this photograph?

A It's a close up of the scar from Makenzie's lateral incision from the original surgery.

Q And this photo was taken by you on December 23rd, 2010?

A Yes.

- - - - -

(Thereupon, Deposition Exhibit 6 was marked for purposes of identification.)

- - - - -

Q Handing you what's been marked as Deposition Exhibit 6; again, just for the record, is this a photograph you took of Makenzie Dietz' leg on December 23rd, 2010?

A Yes.
Q Can you -- is this a -- I probably took these out of order, but is this a photo that shows the nerve conduit in place?
A It is.
Q What structure is it that's being retracted there?
A The biceps musculus tendon unit.
Q And can we actually see the nerve on the margins -- on either margin of the conduit here?
A On the left side you can barely see. So you see the conduit, there's a suture, and right here, that little yellowish, white thing is nerve. Here, I'm not sure if you can see it.
MR. ROSSI: And just so the record is clear, when you said left, you meant left side of the photo?
A Which is proximal for the patient.
MR. ROSSI: And then when you pointed out your comment at the end --
A That's the distal end.
Q The patient's knee is in extension at this point?
A The patient's knee -- well, it's hard to tell.

Q Okay.
A I don't know.
- - - - -
(Thereupon, Deposition Exhibit 7 was marked for purposes of identification.)
- - - - -
Q Handing you Plaintiff's Exhibit 7; doctor, again, just for the record, is that another photograph that you took on December 23rd, 2010 during the surgical procedure?
A Yes, it is.
Q Can you -- is this the portion where you -- is what is being depicted here is you actually marking off the portion of the peroneal nerve that you believe to be injured?
A Yes.
Q And you did that with looks like just a magic marker?
A A surgical marker, yes; a special sterile marker.
Q Understood.
So that's Makenzie Dietz' common peroneal nerve, correct?
A Yes.
Q And that's the condition it was in and that's

the way it appeared on December 23rd, 2010, correct?

A After we dissected it out, yes.

Q It looks like there's two retractors; it looks one is retracting the biceps tendon and muscle, correct?

A Yes.

Q And the other is retracting kind of the skin and the subcutaneous layers?

A Yes.

Q Is the knee in extension or flexion there; can you tell?

A Without having more proximal distal, I don't know.

- - - - -

(Thereupon, Deposition Exhibit 8 was marked for purposes of identification.)

- - - - -

Q Handing you what's been marked as Exhibit Number 8; again, is this a photograph that you took on December 23rd, 2010 during the surgery you performed with Dr. Jones?

A Yes.

Q This appears to be another photograph of the portion of the peroneal nerve that you

identified as being injured, correct?
A Yes.
Q This one is a little bit closer up, so I want to ask some more specific questions about this one.
Can you actually see portions or parts of the suture in this photograph?
A No.
Q Is this after the nerve has been released?
A Yes.
Q Can you see the joint capsule in this photograph?
A No.
Q Maybe just while I have this photo in front of me, when you say -- was this the same view you had when you found the peroneal nerve adhered to the capsule?
A I don't know. The retraction could be the same, could be different. I can't comment on that.
Q Does this photo, in your mind, depict the narrowing that you described in your operative report?
A It does.
Q I'm going to have to point it out, Doctor, but

what is that?
A What is what?
Q It looks a little bulbous to me, but --
A Yes, this is scar. This is --
MR. ROSSI: Why don't you just describe as best you can --
A Right in the center of -- okay. So there's a picture of a lateral knee. In the center of the photo is a segment of peroneal nerve that has two purple dots on it.

Almost equal distance between the two dots is a bulbous appearing area that I recall as being a neuroma or nerve scar.

Just proximal to that, so just to the left, there's a slight narrowing to the nerve compared to the most proximal which is right underneath the biceps tendon.

And as you go distal, so past the other purple dot, you can see that the nerve is fatter and there's a change in color.

So that's what I referred to as the mullerian degeneration in the fatty changes.
Q At this point in time in the procedure, the suture is still embedded in that area between the two purple dots, correct?

A I don't know. I mean, this -- these photographs are from my oral boards to become boarded in plastic surgery, which I am.

Whether the sutures had already been removed or were still there, I -- I don't have any recollection.

Q Let me try it this way: This portion between these purple dots is what you excised, correct?

A Correct.

Q And that's the portion that was sent to pathology, correct?

A Correct.

Q And pathology found sutures, based on your review of the report, within that portion, correct?

A Or if you want to be technical, they found some kind of foreign body something -- polarizable fragments of foreign material, which presumably is suture material.

Q Are you able to use this photo to maybe help me understand the position of the peroneal nerve that we're looking at before you released it away from the capsule?

A No.

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(Thereupon, Deposition Exhibit 9 was marked for purposes of identification.)

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Q Just to be complete, Doctor, I'm showing you what's been marked as Exhibit 9. Again, is this another photograph that you took of Makenzie Dietz?

A Yes.

Q This is a photograph of the surgical scar -- zig zagged scar -- zig zag incision that you described in your operative report of December 23rd, correct?

A Yes.

Q So can we assume that this was taken well after the surgery was performed?

A Yes. I think if -- if you pull up the photograph, on a computer they're actually encoded with something that tells you the date, but I don't recall the exact date.

Q Okay. That'll spare a lot of those questions, I guess.

Are these all the photos that you have?

A Yes.

Q Are you in possession of any e-mails, letters, memos, notes, anything that pertains to this

patient other than the disk and these photographs that you've shown me?

A No.

Q As you sit here today --

A I don't know. I mean, did you ever e-mail me or did Michelle --

MR. ROSSI: Well, that's all privileged. I don't think he's asking about that.

A No. There's no other clinical information or anything related to -- I don't think the mom ever contacted me.

Q What about any -- did you ever make any notes -- handwritten notes or jotting things down on paper about this patient that you kept?

MR. ROSSI: Other than what's in the chart?

MR. DICELLO: Right. Right.

Q Independent from the medical record.

A No.

Q I'm going to take just a couple minutes, go through my notes. I don't think I have any other questions, but I might have a couple follow up.

A Okay.

(Discussion had off the record.)
Q We have your operative note that we've gone through and you've explained to me and I appreciate that. Did you have anything that you recall in terms of conversations with Dr. Jones during the procedure in terms of what your findings were?
A Other than what I've described, no recollection.
Q In other words, when the two of you discovered this, there was no, Oh, that's the problem, there's the problem? Nothing like that, that you remember?
A No. This was four years ago. I honestly don't recall.
Q What about after the procedure; was there a discussion between you and Dr. Jones about what was encountered?
A I'm sure there was, but I don't recall any specifics.
Q I mean, this was an abnormal finding in a patient, right?
A Correct.
Q By habit and practice, would you have expected that you would have discussed that finding with

the doctor?
A I'm sure we did. Whether intra-operatively, post-operatively, but as to specific recollections of those conversations, I don't have any.
Q Did you ever ask him, How did something like that happen?
A I don't think so.
Q As a surgeon, I presume that you suture different structures depending on whatever the procedure is if it calls for it, correct?
A Yes.
Q A surgeon should know what structure he is suturing before he ties off the sutures, correct?
MR. ROSSI: Objection.
You may answer. I think he's just generally asking you a question.
THE WITNESS: You said objection, but you didn't say I could continue.
MR. ROSSI: You're right; I did not.
You may answer.
A I presume so, yes.
Q Okay. And a surgeon, likewise, should know

what structure he is cutting before he cuts, correct?

A Yes.

Q And surgeons should know what sutures are in his operative field, correct?

MR. ROSSI: Same objection to all these questions.

Go ahead. You may answer.

A Yes, but then you have to define what the operative field is.

Q How do you define operative field?

A The area that I'm operating in.

Q So with that qualification, the answer to my last question is yes?

MR. ROSSI: Objection.

Go ahead.

A Rephrase the question please or restate it.

Q Based on your definition of operative field that you gave us, a surgeon should know what structures are in his operative field?

A Yes.

Q You were able to visualize Makenzie Dietz' peroneal nerve after dissection grossly, correct?

A Yes.

Q Did you, as you sit here today, recall encountering any problems locating that nerve?

MR. ROSSI: Objection.

Go ahead, if you can answer.

A I mean, to the extent that Dr. Jones guided me to where the peroneal nerve is, because he knows better than I do, yes, I had difficulty and he helped me and then we found it together.

Q Do you -- as you sit here today, do you have a recollection as to how long it took to identify the peroneal nerve?

A No.

Q I guess I should ask you about this document, too, Doctor, because I think this is your handwriting.

A I have the handwritten operative report in front of me.

Q Is this your handwriting?

A It is.

Q And your findings are, Suture through peroneal nerve, correct?

A Yes.

MR. DICELLO: Doctor, those are all the questions I have. Thanks for your patience.

THE WITNESS: Thank you.

MR. ROSSI: He will read.

(Deposition was concluded at 3:46 p.m.)

(Signature reserved.)

THE STATE OF OHIO, ) SS:
COUNTY OF CUYAHOGA. )

I, Kelly A. Hill, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that PETER LETOURNEAU, M.D., was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed on a computer/printer, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified. I do further certify that I am not a relative, counsel or attorney of 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 4th day of February 2015.

Kelly A. Hill, Notary Public
within and for the State of Ohio
My Commission expires February 16th, 2016.

THE STATE OF )
) SS:
COUNTY OF

Before me, a Notary Public in and for said state and county, personally appeared the above-named PETER LETOURNEAU, M.D., who acknowledged that he did sign the foregoing transcript and that the same is a true and correct transcript of the testimony so given.

IN TESTIMONY WHEREOF, I have hereunto affixed my name and official seal at

this day of , 2015.

PETER LETOURNEAU, M.D.

Notary Public

My Commission expires:

DEPOSITION ERRATA SHEET

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