IN THE DISTRICT COURT OF
HARRIS COUNTY, OF TEXAS
295TH JUDICIAL DISTRICT

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|---|---|---|
| SONIA THOMPSON, | ) | |
| | ) | |
| Plaintiff, | ) | |
| | ) | |
| v. | ) | No. 2015-63735 |
| | ) | |
| JORGE LEIVA, M.D., SAID BINA, M.D., and ZIAD AMR, M.D., | ) | |
| | ) | |
| Defendants. | ) | |

ORAL AND VIDEOTAPED DEPOSITION

RICHARD GORE, M.D., F.A.C.G., F.A.C.P., F.A.C.R., A.G.A.F,

JANUARY 30, 2017

The deposition of RICHARD GORE, M.D., called by the Defendant, for examination, taken pursuant to notice and pursuant to the Texas Rules of Civil Procedure pertaining to the taking of depositions, taken before Joan M. Burke, Certified Shorthand Reporter and Registered Professional Reporter, at Glenbrook Hospital Department of Radiology, 2100 Pfingsten Road, Glenview, Illinois, commencing at 10:58 a.m. on the 30th day of January, A.D. 2017.

A P P E A R A N C E S

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ALSO PRESENT:

Mr. Andrew King, Videographer



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EXHIBITS





10:58 THE VIDEOGRAPHER: The time is 10:58 on January 30th. This is the video deposition of Dr. Richard Gore at Glenbrook Hospital, Department of Radiology, Conference Room 1208, 2100 Pfingsten Road, Glenview, Illinois 60026.

If the court reporter would please swear in the witness.

(Witness sworn.)

MR. HUGHES: By the rules?

MR. PAINTER: Yes.

WHEREUPON:

RICHARD MICHAEL GORE, M.D., called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. HUGHES:

Q. Would you state your name, please?

**A. Yes. My name is Richard Michael Gore, G O R E.**

Q. Dr. Gore, what do you do for a living?

**A. I'm a diagnostic radiologist.**

Q. Okay. You don't do surgery?

**A. No.**

Q. You certainly have not performed a gastric sleeve procedure, right?



**A. No, sir.**

Q. Okay. My name is Matthew Hughes and I represent Dr. Leiva in this case. Dr. Leiva is a surgeon. Are you aware of that?

**A. Yes, I am.**

Q. You are not going to offer opinions today about what the standard of care is for a surgeon, right?

**A. That's correct.**

Q. Because that would be outside of your area of specialty?

**A. That's right.**

Q. It would be outside of your area of training?

**A. Correct.**

Q. And, frankly, you are not qualified to render opinions about the surgical care that Dr. Leiva performed, right?

**A. Correct.**

Q. Okay. You have been retained by the plaintiffs in this case to render an opinion about the radiology issues, right?

**A. That's right.**

Q. That means that you've looked at the upper GI series and the CT scans in this case and

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have formed opinions?
**A. That's correct. And also chest X-rays and other studies that were done as well.**
Q. As part of your daily practice, I assume that you interact with surgeons?
**A. Yes, sir.**
Q. And you offer a benefit to the surgeons when you interact with them, don't you?
**A. I certainly hope so.**
Q. Okay. Is it common for surgeons to defer to your expertise when it comes to reviewing radiology studies?
**A. Most of the time they do, but sometimes they say, Richard, you're dead wrong.**
Q. Okay. But there is something that a surgeon gets from consulting with a radiologist that must be beneficial otherwise it would be just a waste of their time, right?
**A. That's right.**
Q. Okay. So there is some knowledge that you might have about what's on a radiology film that a surgeon would not have, fair?
**A. That's right.**
Q. Otherwise, again, there would be no purpose to talk to the radiologist, the surgeons

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could just look at all the films themselves, right?
**A. That's right.**
Q. In day-to-day practice, it is routine for surgeons to talk to the radiologist or review reports prepared by them, right?
**A. That's correct. Some come down to discuss with us and some just look at the report.**
Q. You are not critical -- if the evidence in this case shows that Dr. Leiva actually reviewed the radiology reports that were prepared by other physicians in this case, radiologists prepared them, that is a normal thing for surgeons to do, right?
**A. Absolutely.**
Q. And you would certainly not be critical of him for reviewing or relying upon the radiology reports that were prepared by other physicians, right?
**A. Yes. They are -- rely on the reports, but sometimes there's a disconnect with what you get in the report and what's happening with the patient and then they usually consult with the radiologist.**
Q. And then even -- and if they consult with

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the radiologist, then they can get additional information from the radiologist about what's on those studies, right?
**A. That's correct, and the radiologist can learn from the surgeon, you know -- you know, what he or she did during the operation.**
Q. Okay. All right. I'm going to go ahead and hand you some documents that I've premarked for your deposition today. One of them is a copy of your deposition notice?
**A. Yes.**
Q. Have you had a chance to review that?
**A. Yes, I have.**
Q. Have you brought your entire file of materials that you've reviewed for this case?
**A. Yes, I have.**
Q. So have you reviewed the deposition of Dr. Leiva?
**A. No.**
Q. Have you reviewed the deposition of Dr. Bina?
**A. No.**
Q. Okay. So in a sense, any explanations they have for what they were doing that were taken from them when they were under oath, you have not

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had the opportunity to see that?
**A. That's correct.**
Q. And since you have been an expert witness many times, I assume that you do not feel that their deposition testimony was important to your opinions in this case?
**A. That's correct. Because I'm just going to be talking about the X-rays and not talking about standard of care for a surgeon.**
Q. Okay. Great. Let me go ahead and hand you what's been marked as Gore Exhibit No. 2. Is this your most up-to-date resume or CV?
**A. Yes, it is.**
Q. Do you -- are there any specific papers that you have published that specifically reference to sleeve gastrectomies and how to look at them in radiographic studies?
**A. I've written on gastric bypass, but also there is a chapter in the book, the Textbook of Gastrointestinal Radiology, which amongst the types of bariatric surgery they talk about -- we talk about sleeve gastrectomy.**
Q. This textbook that you have in front of you, it looks like it's got two volumes, right?
**A. That's correct.**

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Q. It's called the Textbook of Gastrointestinal Radiology, Fourth Edition?

**A. That's right.**

Q. And I assume since you bought it, are there parts of this book that you've written?

**A. Yes. I've edited with my coeditor, Marc Levine. We've edited the entire book. Also we've written a majority of the chapters. There is the chapter on postoperative stomach and duodenum and this chapter was written by Laura Carucci, C A R U C C I, and --**

Q. And that's Chapter 35 of your book?

**A. Chapter 35 and on Pages 651 through 654 she talks about sleeve gastrectomy.**

Q. Is this a textbook that is -- that is used in the education of radiologists?

**A. Yes.**

Q. Okay. Let me go ahead and hand you what's been marked as Exhibit No. 3. This looks like a report that you prepared it looks like around September 16th, 2000 and -- what date?

**A. This was September 16th, 2016.**

Q. Was this report prepared by you?

**A. This -- yeah, I typed this letter.**

Q. The -- the opinions contained in that

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report, are they your own?

**A. Actually this is just a bill.**

Q. Okay. Let's go ahead and hand you Gore Exhibit No. 4. This is dated September 22nd, 2016. Is this a report you prepared?

**A. Yes, it is.**

Q. Okay. So the opinions contained within Exhibit No. 4, are they your own opinions?

**A. Yes, they are.**

Q. They are opinions that you formed after your review of the materials in this case?

**A. That's right.**

Q. And do you stand by the opinions in this case?

**A. Yes, I do.**

Q. Since you have begun reviewing this case, were there any opinions that you formed that you have retracted?

**A. No.**

Q. Now, you have reviewed the radiographic studies that were taken regarding Ms. Thompson, right, during the hospitalizations?

**A. That's right.**

Q. Have you actually reviewed the underlying medical records as well?

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**A. I briefly glanced through them, yes. But, you know, they're quite extensive and I have some notes --**

Q. I'm going to hand you those in a minute.

**A. Right.**

Q. Okay. Beyond that, but what actually have you reviewed? You reviewed this textbook that you -- you helped prepare, right? And you've reviewed the radiographic studies and you've reviewed some parts of the medical record?

**A. Right. And certainly the radiology reports, yes.**

Q. Okay. Let me hand you what's been marked as Exhibit No. 5. Is this an e-mail between you and the plaintiff's lawyer in this case?

**A. Yes.**

Q. Exhibit No. 6 looks like some notes that you prepared. Is that your handwriting?

**A. Yes, it is.**

Q. When you review a case and take notes, I want to know what your normal routine is. Are -- do you write down just what you find particularly pertinent or important?

**A. Okay. Well, in terms of the radiology studies, I actually make a PowerPoint or else I'm**

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**not going to forget -- I'm going to forget what they show. So those are my notes doing the PowerPoint. But the issues that I find important -- because, you know, often the medical records are thousands of pages and so I just write down the important points.**

Q. Okay.

**A. That are important for my opinion.**

Q. Okay. Exhibit No. 7 looks like a summary of your trial testimony?

**A. Yes, it is.**

Q. I mentioned in one of my earlier questions that you've -- you've done a fair amount of expert witnessing; isn't that correct?

**A. I've been a medical expert, yes, in a number of cases.**

Q. How many times would you say?

**A. Boy, over the last 30 years, I've been at trial 26 times and probably about 200 depositions, and probably reviewed 400 cases, something like that.**

Q. Are you charging for your time?

**A. Yes.**

Q. And what do you charge?

**A. $500 hourly.**

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Q. Is that for reviewing records?
**A. Correct.**
Q. Do you have a separate charge for giving a deposition?
**A. No, I don't.**
Q. This case is set for trial in Harris County, Texas. Have you been asked to attend the trial of this case?
**A. Yes, I have.**
Q. Are you going to attend the trial of this case?
**A. Yes, I do. Plan to.**
Q. I believe it's February 20th, but that's, I guess, like anything is subject to change. But if this case gets called to trial on or about February 20th of 2017, would you be available to testify in Harris County?
**A. Yes, I will.**
Q. And you mentioned that you have testified, I think you said, 26 times at trial?
**A. Over the last 30 years.**
Q. Okay. And that's in a bunch of different parts of the United States, right?
**A. That's correct.**
Q. It looks like you have reviewed a number

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of cases in Colorado; is that right?
**A. Yes.**
Q. One in D.C., right?
**A. I think more than one in D.C.**
Q. Okay.
**A. Right.**
Q. You've reviewed at least nine cases in Florida?
**A. Yes.**
Q. At least one case in Georgia and Iowa each?
**A. I think more in Iowa.**
Q. Okay. A number of cases in Illinois?
**A. Yes.**
Q. Okay. And just so the jury knows, we're taking your deposition in a suburb of Chicago, right --
**A. That's right.**
Q. -- today?
And is this where you actually practice medicine?
**A. Well, actually there are four hospitals in our system. It's called NorthShore University HealthSystem. There are four hospitals. We're at Glenbrook today, but I also practice at Evanston**

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**Hospital, Skokie Hospital, and Highland Park Hospital.**
Q. You've never practiced in Houston?
**A. No.**
Q. Have you ever been to the hospital where Ms. Thompson had her surgery?
**A. No, I have not.**
Q. Have you ever met Dr. Leiva?
**A. No.**
Q. Have you ever met Dr. Bina?
**A. No, I have not.**
Q. Have you ever met Ms. Thompson?
**A. No.**
Q. And you certainly have not had an opportunity to examine her, right?
**A. That's correct.**
Q. Okay. You've also reviewed at least one case in Kansas?
**A. Yes.**
Q. Right? A number of cases in Kentucky?
**A. Correct.**
Q. Massachusetts, right?
**A. I -- possibly.**
Q. Maryland?
**A. Yes.**

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Q. Michigan?
**A. Yes.**
Q. At least eight cases in Missouri?
**A. Correct.**
Q. How about Mississippi?
**A. Long time ago, yes.**
Q. Okay. New Hampshire?
**A. Yes.**
Q. Ohio?
**A. Yes.**
Q. Pennsylvania?
**A. Yes.**
Q. Tennessee?
**A. Yes.**
Q. And this is not the only case you have reviewed in Texas, right?
**A. Correct.**
Q. Utah?
**A. Yes.**
Q. And then both Virginia and West Virginia?
**A. Yes.**
Q. Now, of the 26 times you've testified at trial, have -- has the other side also had another radiologist who expressed opinions different from yours?

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**A. I think in the majority of cases they have, but some did not have a radiologist.**

Q. Okay. Doctors disagree all the time, don't they?

**A. Yes, they do.**

Q. Do you acknowledge the fact that doctors can disagree with each other reasonably?

**A. Yes.**

Q. Do you acknowledge that in this case a radiologist looking at the same films you've looked at might come to different opinions than you have come to?

**A. Correct.**

Q. And we know, in fact, that if you go back and review the actual radiology reports in this case, that the radiologists who actually reviewed Ms. Thompson's films at the time that Dr. Leiva was treating her did come to a different opinions from you, correct?

MR. PAINTER: Objection to form.

BY THE WITNESS:

**A. Let's see. One of the radiologists -- and we'll talk about that in my PowerPoint -- did not mention the presence of the hernia, but the person who read the CT study did mention a hernia.**

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**And then Dr. Morello, M O R E L O [sic], he mentioned the paraesophageal hernia.**

Q. Yeah, But Dr. Morello came in and reviewed the films in September, I believe, right?

**A. That's right.**

Q. And if the -- the surgery at issue in this case, I believe, occurred on August the 13th?

**A. Let's see. That's correct.**

Q. Okay. So essentially a month after Dr. Leiva's surgery, a Dr. Morello looks like he read his first radiology study for Miss Leiva [sic]?

**A. That's right.**

Q. But so he was -- but have you seen any other evidence from your review of this case that Dr. Morello played any role in interpreting Ms. Thompson's radiology reports during her initial hospitalization for the gastric sleeve procedure?

**A. No, he did not.**

Q. Okay. And unless Dr. Leiva's a mind reader, he's not going to know what Dr. Morello would have thought about any of the studies if Dr. Morello didn't even see any until about a month after Dr. Leiva's surgery, fair?

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**A. That's correct.**

Q. Have you ever been sued for malpractice?

**A. Oh, yes.**

Q. How many times?

**A. Six times.**

Q. And have you ever had to try one of your malpractice cases?

**A. No.**

Q. Do you feel that you breached the standard of care when you were sued?

**A. Not in these cases, no.**

Q. So even though over -- you have more than a 30-year career, right?

**A. Oh, it's 40 years as a radiologist starting in July, so, yeah.**

Q. And so over 40 years you've been sued four times, but you don't believe -- I'm sorry, six times, but in none of those cases do you believe you breached the standard of care?

**A. That's correct.**

Q. And so I assume in some of those cases, they -- the plaintiff's attorney was able to find a radiologist who criticized your interpretation of some radiology studies?

**A. That's correct.**

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Q. And just because they found a physician to criticize your studies certainly didn't convince you that you breached the standard of care, fair?

**A. That's right.**

Q. Okay. And I mentioned this earlier, but physicians can reasonably disagree with each other, right?

**A. Yes, they can.**

Q. Okay. All right. Now let's go to, if we can, to your report that I believe --

**A. Surely.**

Q. -- we've marked as -- which one is it? May I see the stack? I'll see if I can find it for you. Because I handed them all to you.

**A. Sure. I have another copy if --**

Q. Here we go. It's Exhibit No. -- Gore No. 4 so I want you to be able to refer that while I'm talking to you.

**A. Okay.**

Q. So in your expert report in this case, you actually went through and listed the studies that you looked through, right?

**A. That's correct.**

Q. And then it looks like you basically

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formed two opinions; is that correct? Let's see if I can read these. You reviewed the studies as of August 14th, 2013, right?

**A. Yes.**

Q. So that would be study -- an upper GI series that was done the day after Dr. Leiva's surgery?

**A. That's right.**

Q. And it is your belief that there was a moderate sized paraesophageal hernia present on that film, right?

**A. Correct.**

Q. Which was not an expected or normal appearance following hiatal hernia repair surgery. Did I read that correctly?

**A. That's right.**

Q. Now, on August 14th, 2013, a radiologist named Dr. Roman Raju reviewed an upper GI series and he just referred to it as a hiatal hernia, right?

**A. I don't think he even mentioned the hernia.**

Q. Okay. So another radi -- a radiologist at the time when Dr. Leiva was treating this patient didn't mention or describe the hernia in

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any detail, right?

**A. That's correct.**

Q. Okay. You mention further down in your report that Ms. Thompson had a repeat surgery on September 13th, 2013 for repair of the paraesophageal hernia and gastric volvulus, right?

**A. Correct.**

Q. And what is a gastric volvulus?

**A. A gastric volvulus is when the stomach twists upon itself, and when the stomach twists upon itself, sometimes that can compromise or decrease the blood supply to the stomach and when that happens the blood -- the stomach becomes ischemic, becomes sick, it can ulcerate and ultimately die and get gangrene.**

Q. If this is something that you found from reviewing the September 16th study, was it present on any of the earlier studies?

**A. Not that I saw, no.**

Q. So the volvulus is a very significant finding, fair?

**A. Correct.**

Q. And that was something that you saw as of September 16th; it was not something that was present on any of the films between August 14th

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and August 15th of 2013?

**A. Well, the stomach was twisted upon itself and, you know, I guess -- you know, there is volvulus and there's volvulus. There is some where there is a little bit of a twist and there's some where the twist is so enormous or so significant that kind of blocks the blood supply to the stomach.**

Q. Neither the -- of the two radiologists who reviewed Ms. Thompson's films at the time she was initially admitted, which would be Dr. Roman Raju nor Dr. James Hammond, referenced a gastric volvulus back in August, right?

**A. That's correct.**

Q. And they certainly didn't put in their reports that this patient had a gastric volvulus, right?

**A. Correct.**

Q. And there is no reason for you to believe, I assume, based on the evidence you've seen that Dr. Leiva was ever informed that this patient may have a gastric volvulus back in August of 2013?

**A. That's right.**

Q. Okay. These radiology studies, is there

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a particular image that you think best illustrates the type of hernia that Ms. Thompson may have had as of August 14th, 2013?

**A. Yes, there are a number of images that show that and I do have it on my PowerPoint presentation.**

MR. HUGHES: Okay. I have -- I'd like to go off the record for just a moment.

THE WITNESS: Sure.

MR. HUGHES: I have a binder with some images in it and what I'd like to do is let you have a chance to look through it really fast. And why don't you tell me which one -- if you can, which one of the images would be helpful in demonstrating that. Okay?

THE VIDEOGRAPHER: Going off the record at 11:17.

(Whereupon a short break was taken.)

THE VIDEOGRAPHER: Going back on the record at 11:24 a.m.

BY MR. HUGHES:

Q. Dr. Gore, during the break you've had a chance to go through the -- the basically photographic images of these radiology studies,

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right?

**A. That's correct.**

Q. And put stickies on the ones which are significant as showing as to what type of hernia you believe that Ms. Thompson had after her surgery, right?

**A. Correct.**

Q. Okay. And what I'd like to do is just to move this along as quickly as possible to see if we can, just if you can tell me the date and the image number.

**A. Okay.**

Q. And then that way we can just work through them and then we can just -- so we can just list them all.

**A. Okay. All right. I'm first going to be talking about the significant images on the CT study done on Sonia Grand Thompson at North Cypress Hospital and this was -- study was done on August 15th, 2013. And, let's see. This was done at 21 -- at 9:08 in the evening. Okay. So Image 69 out of 128 --**

Q. Okay.

**A. -- of Series 400/7; Image 70 out of 128, Series 400/7; Image 71 of 128, Series 400/7;**

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**Image 72 of 128 of Series 400/7; Image 74 of 128, Series 400/7. And these are the coronal images, the ones I'm talking about now. And then on also Image 76 of 128, Series 400/7.**

Q. Okay. And then we have another volume here. If you can tell me -- you've also marked some in this other volume, correct?

**A. Correct.**

Q. If you could do the same thing for me, please, and just tell me what the date and then the image numbers.

**A. Oh, there's -- here's the first part of the CT. So -- all right. I've marked that as well.**

**Okay. So I've marked some images from the upper GI that was performed on Sonia Thompson on 8/14/13. And okay. This is Series 1/6, Image 1 of 1; Series 2/6, Image 1 of 1; Series 3/6, Image 1 of 1; Series 4/6, Image 1 of 1.**

**Okay. And then we go to the upper GI study that was performed on Ms. Thompson on 8/16/13. And image -- or set -- or Series 3 of 7, Image 1 of 1; Series 4 of 7, Image 1.**

**And then we go to Ms. Thompson's**

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**upper GI that was done on 9/11/13 and Series 4 of 7, Image 1 of 1; Series 5 of 7, Image 1 of 1; Series of 7, Image 1 of 1; Image 7 of 7, Image 1 of 1.**

**And now we're going to go to the CT study that was performed on 8/15/13. And actually this is the CT study that I talked about earlier. There were the coronal images which I discussed last time and now I'm going to be talking about the axial images. And so on the CT study, Image 1 out of 186, Series 5 of 7; Image 2 of 86, Series 5 of 7; Image 3 of 86, Series 5 of 7; Image 4 of 86, Series 5 of 7.**

**And there are some other images that were done later in the scan, but they showed the same anatomic area, but I don't think --**

Q. Okay.

**A. Do you want -- I don't think it's necessary to mark them though, but I can.**

Q. Well, if there's one actually you're pointing at right now. Can you tell me what that --

**A. Okay. I'll put a sticker there. I'll point to a few of them. So this is Image 2 out of 55, Series 2 of 7; Image 3 out of 55, Image 2 of**

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**7; Image 4 out of 55, image -- set 2 of 7; Image 5 of 55, set 2 of 7; Set 2 of 7, Image 6 of 55; and then Image 7 of 55, set 2 of 7. And these are the axial CT images.**

Q. Right. My understanding is that the plaintiff's lawyer will be asking -- you have a PowerPoint presentation that you're going to be showing us in a few minutes?

**A. Right.**

Q. So I'll let him ask you about that.

I want to draw your attention now to the radiology reports. Do you have access to those?

**A. Let's see. Okay.**

Q. Okay. All right. I believe if you look at the bottom of the page, I'm going to start with the radiology report that's -- was prepared by Dr. Roman Raju on August 14th, 2013. It should be Page 504 on the bottom. Do you have different page numbers in yours?

**A. I have different page numbers, but I do have the report of upper GI on 8/14/13.**

Q. Okay. And I'm looking at an upper GI without KUB. Do you have that report?

**A. Yes.**

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Q. Okay. And this report was dictated by Roman Raju?

**A. Correct.**

Q. And the impression was unremarkable post gastric sleeve study, right?

**A. Correct.**

Q. There is -- this report doesn't mention anything about the presence of a paraesophageal hernia, does it?

**A. No, it does not.**

Q. Then I want to show you -- draw your attention, please, to the August 15th, 2013 CT ABD/pelvis with and without contrast?

**A. Yes.**

Q. Okay. That one was dictated by Dr. James Hammond?

**A. That's correct.**

Q. And you've reviewed that, have you not?

**A. Yes, I have.**

Q. Okay. And he states under -- the discussion section it says post surgical change of the stomach is noted. Hiatal hernia is present, right?

**A. Correct.**

Q. He doesn't mention or define what type of

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hiatal hernia, does he?

**A. No, he does not.**

Q. If you go under impression, it states small left effusion and mild basilar atelectasis, right?

**A. Correct.**

Q. And hiatal hernia post surgical change of the stomach?

**A. That's right.**

Q. Doesn't mention anything about a paraesophageal hernia, does it?

**A. No, he doesn't specify the type of hernia.**

Q. And does -- is there any mention in either one of these reports that the radiologist felt that there was anything like a gastric volvulus or any other acute problem with the stomach that required the surgeon's attention?

**A. No, there is not.**

Q. If -- if a radiology report shows the presence of a volvulus, can that be a very serious condition?

**A. A volvulus can be serious, yes.**

Q. Is that something that a radiologist should bring to the attention of a surgeon if they

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find it on a study?

**A. If there is a volvulus that's major that's causing obstruction, yes.**

Q. And is -- you don't have an opinion in this case that such a volvulus existed at the time that Ms. Park -- I'm sorry, Ms. Thompson was hospitalized on August 13th through the 15th, right?

**A. No, there was not a complicated volvulus at that time, correct.**

Q. Okay. Now, if you draw your attention to August 16th, 2013, UGI without KUB?

**A. Yes.**

Q. That was dictated by Dr. Roman Raju. Okay. His findings were contrast flows from the esophagus into the gastric remnant without impedance, right?

**A. That's right.**

Q. That implies that the ability to get contrast down into the stomach occurred without any problems, right?

**A. Right. There was no blockage.**

Q. Okay. Impression was no abnormality seen after the gastric sleeve surgery?

**A. That's correct.**

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Q. Does he mention anything about the presence of a paraesophageal hernia as of August 16th, 2013?

**A. No, he does not.**

Q. Now I'm going to draw your attention to the UGI with KUB that was interpreted by Dr. Frank Morello on September 13th, 2013. Have you had a chance to review this study before?

**A. Yes, I have.**

Q. Okay. His findings were a moderate sized paraesophageal hiatal hernia is again noted unchanged in appearance from the prior exam. However, this is the first time that the phrase paraesophageal hiatal hernia is included in any of these radiology reports, fair?

**A. That's right.**

Q. The contrast was delayed -- has delayed emptying from the esophagus into the hernia as well as exiting the hernia into the remainder of the subdiaphragmatic stomach and small bowel. Right? So now there seems to some impedance, fair?

**A. That's what he stated.**

Q. He -- under impression, he has moderate sized paraesophageal hiatal hernia with partially

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obstructed changes within the hernia from the esophagus and exiting the hernia into the subdiaphragmatic stomach, right?

**A. Correct.**

Q. If you compare this UGI from September 11 with Dr. Raju's UGI from August 16th, there seems to some significant changes, fair?

**A. In the reports or --**

Q. Yes.

**A. -- what the X-rays actually showed?**

Q. In the reports?

**A. There's really not very much change on the X-ray, but there is certainly change in the report, right.**

Q. Right. And I'm focusing on the reports if you can for a moment. So what is actually being reported out by the radiologist on August 16th versus on September 11th are significant differences, fair?

**A. Yes. That's correct.**

Q. Okay. And other healthcare providers have a right and a normal practice of being able to rely upon the radiology reports that are prepared by radiologists, right?

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**A. That's correct. And that's the usual situation, but sometimes there is a disconnect. You know, I say something in my report and then the surgeon come -- but then why, you know, everything looks fine, then, you know, why is the patient so symptomatic. So, you know, when there is the disconnect, you know, everything looks hunky-dory on the X-ray, but the patient's doing poorly clinically, then that -- then there's something wrong. There's a disconnect somewhere.**

MR. LUCCIA: Pardon me. I need to object to the last part of that answer as nonresponsive.

BY MR. HUGHES:

Q. Right. And I have a very simple question for you. Would you agree that the radiology report as written on September 11th represents a significant change from the radiology report that was written on August 16th?

**A. Yes, I would.**

MR. HUGHES: Okay. At this point I'm going to go ahead and pass the witness because I think Mr. Painter wants to ask you some questions and I reserve the right to ask additional questions.

MR. PAINTER: Do you want to do any cross before we go over his PowerPoint?

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MR. LUCCIA: No, do his PowerPoint and then I'll cross.

THE WITNESS: Actually can I take a bathroom break?

MR. LUCCIA: Yeah, sure.

THE WITNESS: Because I'm the oldest guy here, so --

MR. PAINTER: We'll go off the record.

THE VIDEOGRAPHER: Going off the record at 11:36.

(Whereupon a short break was taken.)

THE VIDEOGRAPHER: We are back on the record at 11:43.

BY MR. HUGHES:

Q. Dr. Gore, I have one more question I realized at the break is that you have brought with you paper copies of the PowerPoint presentation you're getting ready to show us and I've gone ahead and marked a copy of your PowerPoint presentation as Gore Exhibit No. 8; is that correct?

**A. That's correct.**

Q. And is that basically going to be a paper version of what we're going to see on the screen behind you in a minute?

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**A. That's right.**

MR. HUGHES: Thank you, sir. At this point I'll go ahead and pass the witness.

EXAMINATION

BY MR. PAINTER:

Q. Dr. Gore, could you just reintroduce yourself for the jury, please? What's your name?

**A. Yes. My name is Richard Gore. And I'm a diagnostic radiologist at NorthShore University HealthSystem where excellence surrounds you. It's part of our ads.**

Q. Okay. Dr. Gore, we've previously marked Deposition Exhibit 2, which you've testified, I believe, is a true and correct copy of your current resume or curriculum vitae, correct?

**A. That's right.**

Q. It's 117 pages; is that right?

**A. Yes.**

Q. And, Dr. Gore, if you can just tell the jury where did you go to medical school?

**A. Okay. I went to medical school at Northwestern. It was a combined six-year program where I got my Bachelor's degree and my medical degree in six years. And so that was from '71 to '77.**

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Q. And after you graduated from medical school in '77, did you do some additional training?

**A. Right. I then did a radiology residency also at Northwestern from 1977 to 1981.**

Q. Dr. Gore, have you had the occasion during your career to have any academic appointments with medical schools?

**A. Yes, I have.**

Q. Could you describe those briefly, please?

**A. All right. First it was at Northwestern so from when I returned from my fellowship in abdominal imaging in 1982, I returned to my alma mater, Northwestern, and I went through the ranks from assistant to associate to full professor. And so I was a full professor there until 2009 and in 2009 for some reason, our hospital got into a fight with the Dean downtown and we changed our affiliation from Northwestern -- broke my heart -- to the University of Chicago. And so now I'm an emeritus professor at Northwestern and a professor now at the University of Chicago.**

Q. So you're a full professor at the University of Chicago?

**A. Yes.**

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Q. Doctor, what states or -- let me ask this a different way.

Doctor, are you licensed to practice medicine in any states?

**A. Yes.**

Q. How many states?

**A. Two states.**

Q. Tell us about that, please.

**A. Okay. Illinois, where I practice, and also I did my fellowship in California, in San Francisco, and I kept my license active thinking that, oh, maybe when I'm getting old, like my current age, I'll retire to California, but I think it's going to be too expensive to live there, so --**

Q. And --

**A. That's why --**

Q. I'm sorry.

**A. No.**

Q. And, Doctor, do you have any board certifications?

**A. Yes. I'm board-certified in diagnostic radiology.**

Q. Doctor, we're taking your deposition today and it's January 30th, 2017 and we're

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outside of Chicago at a hospital; is that correct?

**A. That's right.**

Q. It's one of the hospitals where you practice?

**A. Yes.**

Q. Okay. And you -- if you weren't giving this deposition today, what would you be doing on this workday?

**A. Okay. On this workday actually I'm working the 3:00 to 10:00 shift so it sounds like working at the Chrysler plant, but I'm covering the emergency room from 3:00 to 10:00.**

Q. Okay. And you've had occasion to give trial testimony and deposition testimony before over your career; is that correct?

**A. Yes.**

Q. And you charge for your time; is that correct?

**A. That's correct.**

Q. What is the purpose of charging for your time?

**A. Well, it takes me away from my other activities, you know, and sometimes I need to get coverage for when I do things like that, so that's why I charge for my time.**

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Q. Doctor, you've -- during the course of your clinical and academic career, have you had the opportunity to have some papers and so forth published?

**A. Yes, I have.**

Q. One of your publications is the Textbook of Gastrointestinal Radiology; is that correct?

**A. That's correct.**

Q. If you hold up a copy of that, please?

**A. Surely.**

Q. It's actually, I guess, two volumes, correct?

**A. Two volumes, that's right.**

Q. And you're one the authors of this textbook?

**A. I was the lead editor and one of the major contributors to the book.**

Q. Okay.

**A. And it's available at Amazon.com.**

Q. Okay. Thank you, Doctor.

Now, as a result of your expertise in radiology, and in particular abdominal radiology, have you been called upon to give opinions in lawsuits like this?

**A. Yes, I have.**

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Q. Okay. And this case, of course, concerns the care that was provided to Sonia Thompson in Harris county, Texas, at North Cypress Medical Center. You understand that?

**A. Yes, I do.**

Q. And as a part of your preparation for your opinions and your testimony, you have reviewed a variety of materials; is that right?

**A. That's correct.**

Q. Just by way of summary, could you tell the jury the types or just the --

**A. Okay.**

Q. The types of materials you reviewed?

**A. All right. I have reviewed -- Mrs. Thompson's had multiple upper GI series, which we'll talk about, and she also had CT scans and then she also had plain chest X-rays and abdominal X-rays. So she had quite a few studies.**

Q. Did you review the radiology reports as well?

**A. Yes, I did.**

Q. Okay. Now, I'd like -- I understand that for the purposes of organizing your opinions and your testimony you prepared a PowerPoint; is that correct?

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**A. That's correct.**

Q. So I'd like to go ahead and ask you, Doctor, if you could start that PowerPoint.

**A. Okay.**

Q. Okay. And Doctor, we have here, I guess, three slides that are coming up that I believe are graphic -- you can look at this copy if you'd like.

**A. Sure.**

Q. Slides 1 to 3 are depictions of certain parts of the human body; is that correct?

**A. That's correct.**

Q. Okay. And how are you familiar with those parts of the human body?

**A. Well, first of all, you learn this in medical school. And, you know, also I'm a GI radiologist so obviously the GI tract is the most important part of the body, at least to a GI radiologist, so here --**

Q. Let me ask one more question about this. And in your -- do you have an opinion as to whether or not these Slides 1 to 3 that you've chosen are accurate depictions of the body parts that are reflected?

**A. Well, actually the first slide shows the male. But in a female, the stomach, the intestine are the same.**

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Q. Okay. And so would your answer be that these -- you've selected some slides that accurately depict the body parts reflected?

**A. That's correct.**

Q. Okay. And tell us about this first slide here?

**A. Okay. The first slide is to show the parts of the GI tract. First is the mouth and then we get to the esophagus or gullet. Then you get into the stomach and then the duodenum which is the first part of the small intestine. Even though it's called small intestine, it's actually the largest part. It's 22 feet long. And then we get to the colon, also known as the large intestine, and that's about six feet long. And this is just to show the folks, you know, the anatomy of the GI tract.**

Q. Doctor, let's look at the next slide, please. And what is this illustration?

**A. Okay. Here we're honing down on where the anatomy of interest. So we're looking at this patient and here we can see the diaphragm. And the diaphragm is that muscle that separates your**

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**belly from your chest. It's very important for respiration, for you to able to breathe. And also when you've got, you know, pathology or cancer or pus in your belly, it stops it from going into your chest; similarly when you get cancer in your chest, the diagram helps prevent it from going down into your belly. But this shows the anatomy.**

**Here we can see the esophagus. And then the esophagus goes through the diaphragm through a hole called the hiatus. It's called the esophageal hiatus. And then we get into the stomach.**

Q. Let's go to the next slide, please.

**A. All right.**

Q. Now, this slide says vertical sleeve gastrectomy; is that correct?

**A. That's right.**

Q. What is your understanding about how that relates to Sonia Thompson?

**A. My understanding is that Sonia Thompson had a vertical sleeve gastrectomy procedure and hiatal hernia repair on August 13th, 2013.**

Q. If you could just explain -- first of all, this chart is -- or rather this illustration that you've selected depicts what?

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**A. Okay. Now, normally the stomach would be this area, all this area. However, when you get a vertical sleeve gastrectomy procedure, the surgeon will take out about 70 to 85 percent of your stomach and then give you just a little bitty remnant, you know, just a little bit left over. And the idea about that is when you eat food, you get full immediately or and you feel full and so that's going to -- people who are obese, it's going to help control their appetite because you just eat a little bit. And rather than a whole big stomach to go into, it's just going to fill this little bitty part of the stomach that's left and you feel like you've had a huge meal after just a few mouthfuls and that's the rationale for doing that.**

Q. Now, Doctor, you have a number -- I think this slide and then the three slides that follow it are graphic representations of the stomach and this procedure. How is it that you're familiar with this procedure? Is that from your medical training?

**A. Actually the gastric sleeve was not around in my medical training. But probably gastric sleeve came about in 1999 and actually at**

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**our hospital it's now the most common form of bariatric surgery or weight reduction surgery.**

Q. And so these next images, these -- this image and the next three are accurate depictions, in your opinion, of what's reflected?

**A. Yes. Should I go to the next slide?**

Q. Yes, please.

**A. Okay. And so the next slide, actually now we're just going to be talking about hernias. Before we were talking about what you do during a sleeve gastrectomy, but we're going to be talking about hiatal hernia. And remember the esophagus goes into the abdomen through the hiatus. And this is the normal relationship. Here we see stomach and diaphragm and esophagus.**

**When you have a sliding hiatal hernia, which is very, very common -- I have one -- I think everybody over 60 or most people over 60 has a little one. Here we can see a sliding hiatal hernia. And then there is a slightly different variant, paraesophageal. So here the esophagus comes to the normal spot, but here a little part of the stomach pooches up.**

Q. Doctor, so let me ask you this. Are these -- on the two -- on the right side of this,

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you have a sliding hiatal hernia and a paraesophageal hiatal hernia, correct?

**A. Right. And again, you know, a hiatal hernia is kind of a broad waste -- not a wastebasket, but it's a broad way of talking about hernias. There is a sliding, and there a paraesophageal, and actually on the next slide, if --**

Q. Please go ahead.

**A. -- I can go to it, actually there are combined hernias. Okay. So -- and that's what Sonia had at the -- after the surgery, so --**

Q. Let me stop you here for just a moment. So -- and I'm going to ask you about each of these in turn. So if you could -- we see up here a Type I in the upper left-hand corner. What's a Type I hernia?

**A. Okay. A Type I hernia is the one that most commonly comes with aging. It can also come -- and it's very common where just a little part of your stomach pooches up above your diaphragm and that's -- and so this is called -- here's the diaphragm. And here's your esophageal hiatus or opening of the diaphragm. And here is the hernia pooching up and here's the esophagus.**

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Q. What about Type II?

**A. Okay. Type II is a pure paraesophageal. So here the esophagus goes south of the diaphragm as it should, but for some reason this little part of the stomach pooches up. And para means next to, like parallel, next to the esophagus. So that's paraesophageal. And so that's called a paraesophageal hernia.**

Q. And tell us about Type III?

**A. And Type III is actually what Sonia had and most people with paraesophageal hernias, a little bit of both. Here the stomach comes up and the diaphragm does not go far south enough. And here we see a little extra stomach pooching up. So this is a -- Type III is a combination of Type I and Type II, and a lot of people just call this a hiatal hernia.**

Q. And I want to ask you just a general question. Is there any significance or importance about repairing a hiatal hernia in a patient who's under going a gastric sleeve surgery?

**A. Yes, there is.**

Q. Let's go to the next slide. If you can explain that, please.

**A. Surely. Okay. So this is the normal**

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**stomach. And this is the -- the top here. We can see the esophagus and here we can see the diaphragm and the normal stomach.**

11:57 **Okay. When you have a gastric sleeve, remember your stomach gets real small. All right. Now, when you have a hiatal hernia, you're more likely to have stuff in your stomach, you're prone to get heartburn and reflux. And so that's more common when you have a hiatal hernia.**

11:57 **But if you've got a hiatal hernia and a narrowed stomach to boot, as we see here -- because, you know, first of all, you've got that real narrow stomach, you've got the hiatal hernia, you're much more likely to reflux and feel just miserable if you have, you know, the gastric sleeve and you leave the hernia there.**

11:57 **So you've got to reduce the hernia and also do your gastric sleeve or otherwise, God, you got the double whammy here. You've got the hernia that's going to make you reflex, and you've got the narrow stomach that can't hold much and that's going to cause reflux as well. So you don't want to that get that double whammy so that's why it's important to repair both.**

11:57 Q. Doctor, I want to just switch gears a

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little bit and have you educate the jury a little bit about some of the procedures, the radiology procedures that can be done after a bariatric surgery like a gastric sleeve.

11:58 **A. Okay.**

11:58 Q. One of them we'll talk about is the upper GI; is that correct?

11:58 **A. Correct.**

11:58 Q. Can we go to the next slide?

11:58 **A. Surely. All right. So after a patient gets a bariatric or weight reduction surgery, you know, the surgeons there, you know, are cutting and snipping and you want to make sure if there is a leak or not. And so what we typically do is we have the patient drink some contrast material. Usually it contains iodine, but sometimes you can use barium instead. And so here's the fluoroscope machine. And you have the patient drink the barium and then the radiologist as the patient is drinking watches on the monitor.**

11:58 Q. Okay. Doctor, then the next one is -- I guess what is this picture?

11:58 **A. This is a person actually undergoing a GI study. So here the patient is lying on the table. They're drinking the contrast material -- it**

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**tastes terrible unfortunately -- and then here's the fluoroscope and here is the monitor which the radiologist can watch while the exam is going on. And also we take hard copy images. You know, we take -- they're called spot films during the upper GI study.**

11:59 Q. Now, another type of radiology study that we'll encounter in your testimony is the abdominal CT; is that correct?

11:59 **A. That's correct.**

11:59 Q. You could just show us the next picture and tell us what that is of?

11:59 **A. Okay. The next picture is somebody going into a CT scanner. So, you know, as I said, usually after you have stomach surgery or any type of stomach or esophagus surgery, you then get a GI study to make sure the patient has a leak.**

11:59 **But, you know, if the GI study doesn't show all the information that we need to know, we then often will send the patient for a CAT scan or CT as well. And this is the CT scan machine and a patient about to go into the CT scanner. And what it is, it's -- it uses X-rays, but it uses a very powerful computer to slice your body like a loaf of bread or a tomato or something**

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**like that. And I can show you --**

12:00 Q. You can show us a couple of those.

12:00 **A. Yeah. Okay. So this is the CT scanner. And, you know, when I first started in radiology, this technology was in its infancy, but now it's just amazing what it can show. And it gives us an image of the body as we see here. And as I said, you know, it can slice you, you know, like an orange or a loaf of bread.**

12:00 **And another nice thing about the CT scanner, especially with the modern CT scanners, it can slice you like a loaf of bread, but can also slice you like a Subway sandwich, the long way. And so that's called the coronal plane, and we'll be looking at some images in the coronal plane. You know, patients in those scanner -- okay, you ask the computer, you know, you show me what it's like slicing a person like a loaf of bread. Now what does it look -- what does the patient look like like we're slicing like a Subway sandwich. I want to see that little piece of meat in the inside of it.**

12:01 **All right. So that's the plane. And then we can talk about some of your image --**

12:01 Q. Yeah, I'd like to do that, but first I

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want to ask you a few questions just about these images, 7 to 12, slides 7 to 12. Those depict radiology equipment and processes that you're familiar with; is that correct?

**A. That's correct.**

Q. And they depict them accurately; is that correct?

**A. Yes.**

Q. And you're familiar with them through your education and training?

MR. HUGHES: Objection.

THE WITNESS: Yes.

MR. HUGHES: Leading.

BY MR. PAINTER:

Q. How are you familiar with them?

**A. This is bread and butter of what I do on a daily basis since 1977. Well, GI studies since '77 and, you know, CT was in its infancy back in '77, but, boy, this is bread and butter what I do daily.**

Q. Okay. Doctor, now that we've -- you've given the jury an overview of the different types of images that can be taken radiologically after a surgery of this type, I'd like to, as you had suggested, get into some of those images now. If

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we go to Slide 13. And this is what, the -- the images we're about to see are from an upper GI of what date?

**A. This was done on 8/14/13. And that was the day after Sonia had her laparoscopic sleeve gastrectomy and hiatal hernia repair.**

Q. So just to give the jury context, we're looking at on August 13th of 2013, the defendants performed the gastric sleeve surgery on Ms. Thompson, correct?

**A. And hernia repair.**

Q. And the hernia repair. Thank you. And the images we're about to look at are from the day after those procedures, correct?

**A. That's correct.**

Q. Okay. So let's go into the first image there.

**A. Okay.**

Q. And could you tell us what this shows?

**A. Okay. This is image number -- if we look at the top here, this is set 2 -- or Series 2 of 6, Image 1 of 1. And we're looking at -- on radiology, when you're looking at the GI study it's as if we're looking at the patient. So here's the patient's right. Here's the patient's**

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**left. Here's the diaphragm. Here is the heart. Here is the esophagus. Here is the stomach.**

**And I have my arrows here pointing to the diaphragm. This is that structure that goes like this. And so we can see there's part of the stomach above the diaphragm so the patient has a hiatal hernia. And actually it's -- we talked about the one that's combined. You know, it's part, you know, sliding and part paraesophageal. But it's all called -- you know, the overarching way of calling them is just hiatal hernias.**

Q. Okay. So according to the image that we're looking at now, where is the esophagus located in relation to the diaphragm?

**A. Okay. So here's the esophagus. And here is part of the stomach. And both of these are above the diaphragm.**

Q. Okay.

**A. And the diaphragm is depicted by the yellow arrows.**

Q. And you would in a normal -- in a normal situation, you would expect the diaphragm -- rather the esophagus and the diaphragm to be located where in relation to the diaphragm?

**A. They should be south. Okay. So this**

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**part of the stomach should be south of this line.**

Q. Okay. Let's look at the next image.

**A. Okay.**

Q. Slide 15. What does this show?

**A. Okay. So this also shows there is the hernia. And then the arrows here point to the diaphragm. So here is the diaphragm. Here is the esophagus. And here's the herniated stomach.**

Q. Okay. Next slide. What does this show?

**A. Okay. Next slide, okay, it shows the diaphragm, you know, depicted by these yellow arrows. And then it shows the hernia. And then here we can see the esophagus. Here's the stomach. Here's the diaphragm. So this thing should be south of the diaphragm, not north of it.**

Q. Okay. What's the next one show?

**A. It kind of shows the same thing. So here we can see the hernia and the diaphragm and this thing is above the diaphragm.**

Q. So the four images that we looked at, are they all from the upper GI study done one day post-op on August 14th, 2013?

**A. Correct.**

Q. Okay. Now, what is, generally speaking, what's the purpose of an upper GI that's performed

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after a bariatric procedure such as this?

**A. Okay. After a bariatric or weight reduction surgery or any type of surgery on your stomach or esophagus, you do the examination the first day because you want to determine is there a leak. You know, the surgeon's been in there cutting, and they did some sewing, stitching things together. Now, did that open up, and looking primarily for a leak.**

Q. When you reviewed these images of the upper GI study done one day after the procedures, did you see any evidence of a leak?

**A. No, I did not.**

Q. Did you see any evidence of an obstruction?

**A. No.**

Q. Okay. So let's go to the next slide. And this is a -- is what?

**A. Okay. This is the report of Dr. Roman Raju that he issued on his examination.**

Q. He is the radiologist who read the examination at the time?

**A. He would have been the radiologist who both read and performed the examination.**

Q. Now, what does the history state there on

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Dr. Raju's report?

**A. It says gastric sleeve.**

Q. Okay. Do you see any mention of the hernia repair surgery on the history on this report?

**A. No, I don't.**

Q. Do you see any mention of any reference at all to the hernia on this report?

**A. No, I don't.**

Q. Okay. Let's move on to the next slide. And we're going into a different type of image; is that correct?

**A. That's correct.**

Q. And this is the CT?

**A. Right.**

Q. The date is what?

**A. Okay. The date of the CT is 8/15/13. And this was two days after Sonia had her surgery.**

Q. Okay. And let's go to the next slide. What is this again for context?

**A. This is for context. Again, when you get a CT scan, you can slice a person like a tomato or a banana. This is slicing a person like a Subway sandwich. So I'm cutting you from stem to stern and I'm going to see that little piece of meat**

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**inside the Subway sandwich.**

Q. Let's go to Slide 21. What is this? This is one of the images of the CT?

**A. Right. There is a CT. And this is called the coronal reformatted image and you tell the computer show me the patient as if we're looking at the patient. So this is -- here is Sonia's liver and kidneys. Right kidney, left kidney. And here is the spine. And the yellow arrow is the right diaphragm and the other yellow arrow is the left diaphragm. And then you can see the hernia above the diaphragm here. So she had a hernia at this point.**

Q. Okay. If you can just point out for the jury what part of the hernia is the esophagus, what part of the hernia is the stomach, in your opinion?

**A. Okay. This part is the esophagus and this part is the stomach.**

Q. Okay. Let's go to the next slide, Slide 22, please.

**A. Right.**

Q. If you tell the jury what this is about here?

**A. Okay. So this is -- Slide No. 22 and**

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**this is Image 76 of 128, Series 400/7. And here I put a picture from Sonia's upper GI that was done the prior day over on the bottom corner here, and then the little arrow coming down is the right diaphragm, here's the left diaphragm. And here we can see the hernia. And so it's pretty similar to the hernia that we see on the upper GI study.**

Q. Okay. And if you could -- I want to ask just generally speaking, if I have the dates correct, we had August 12th was the surgeries, August 13th was the upper GI, August 14th was -- I'm sorry -- August 13th -- Let me start all over.

**A. All right.**

Q. If we have the dates correct, August 13th, 2013 was the -- were the surgical procedures?

**A. Right.**

Q. The 13th, the next day, was the upper GI?

**A. Correct.**

Q. And then now we're looking -- the top image is the abdominal CT of the 14th -- sorry, the 15th?

**A. The 15th, right.**

Q. Okay. I'm getting my dates mixed up. Now, why are -- just generally

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speaking, why are CT -- abdominal CTs ordered in a post bariatric surgical patient who's already had an upper GI?

**A. Okay. Why would you order a CT is that we did the upper GI series, but, you know, the patient's still got problems but we haven't found the reason for the patient's problems yet. And so, you know, CT takes it the extra yard. It can sometimes show a leak that the upper GI may not show and sometimes can show a hernia that the upper GI series. So you do your upper GI series and everything according to the report is okay. You say why is the patient still having problems, so that's when you would order the CT.**

Q. Okay. And let's go then -- so to your opinion then regarding these two comparison studies would be they're similar, they're different, they're the same?

**A. Ah --**

Q. In terms of what they reflect with regard to herniations?

**A. We're getting the same information two different ways.**

Q. Okay. Got you.

Let's go to Slide 23, please. And

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what is -- this is also a CT image?

**A. This is a CT coronal reformatted image. Here we see liver, right kidney, left kidney, aorta, spine. So the yellow arrow is the right diaphragm. Then we see the left diaphragm. And then the hernia.**

Q. Okay. Let's go to the next slide. This is another CT image?

**A. Yes. Another CT image from the same series. This is a coronal as if we're looking at Sonia. Here is her liver, right kidney, left kidney, right diaphragm, left diaphragm. Then we see the hernia.**

Q. Let me ask you a question just generally speaking. When you do an abdominal CT like this, you get more than one image?

**A. Oh, nowadays we get hundreds and hundreds of images, yeah.**

Q. And so these -- are these slides that you're going through right now representative of the images that show herniation in your opinion?

**A. That's correct.**

Q. Okay. Let's just go to the next slide.

**A. And it's the same thing again. Here we see the right diaphragm and the left diaphragm and**

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**there we can see the hernia. Okay.**

Q. And let's go to Slide 26, please.

**A. Slide 26, okay. This is at a slightly different level and now Sonia's stomach is now going into the abdomen where it belongs. So there it's beneath the hiatus.**

Q. Okay. What about in Slide 27, what does that show?

**A. Okay. I actually measured the size of her hernia, and I measured it as 7.1 by 4.9 centimeters. And so what you can do, it's kind of neat on the computer, you can say computer measure from Point A to Point B and measure from Point C to Point B and it gives you a very accurate measurement. You know, that's how we measure hernias, that's how we measure size of tumors or aneurysms, things like that.**

Q. So let's move to the next slide. And for context, we're getting ready to look at some additional slices or views of the CT?

**A. Right.**

Q. And what are they going to be of?

**A. Okay. This is a CT study. You know, this is the same scan. That's the beauty of CT. You just go through the patient once and you can**

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**tell the computer show me the patient from the side or slice them like a tomato or slice them like a Subway sandwich. Now we're slicing Sonia in the transverse plane like an orange or an apple.**

Q. Let's look at the next slide, Slide 29. What does this depict?

**A. Okay. This is Set 3 of 7, Image 3 of 89. And here we can see the heart. Here is the spine, the aorta. The lungs are the black area. And she had a little bit of fluid postoperatively in her stomach and that's -- was reported by the doctor who read the exam. And so here we can see the hernia.**

**And I guess we see the same thing on the Slide Number 30. We see the hernia. And Slide Number 31 we see the hernia once again.**

Q. I think we have two more slides.

**A. Yeah.**

Q. Slide 32, what does it show?

**A. So again Slide Number 32 here we see the heart, the liver, the aorta, the spleen, the inferior vena cava. There is the hernia.**

Q. What about Slide 33?

**A. And --**

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Q. What does it show?

**A. Same thing. It shows there is a hiatal hernia at this point. And here is the liver, the heart, the spleen, the lungs, and a small pleural effusion, a little bit of fluid in her chest.**

Q. Okay. By way of review before we get into the radiology report, I want to ask you just a couple of questions. In your opinion, was a herniation present, a hiatal hernia present on the upper GI that was done on the first postoperative day, that's August 14th, 2013?

**A. Yes, it was.**

Q. Okay. Now, we've just gone through a series of slides from the abdominal CT that was done the next day, August 15th. Do you have an opinion as to whether or not a hernia was present, hiatal hernia was present on those images?

**A. A hiatal hernia was present at that time as well.**

Q. Okay. Now, let's look at the next slide, Slide 34. And could you identify what this document is just generally?

**A. Okay. This is the CT report that was generated or dictated by Dr. James Hammond on the CT study performed on 8/15/2013.**

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Q. Now, Dr. Hammond was the radiologist who reviewed those CT images?

**A. That's correct.**

Q. And he reviewed them at the time of the treatment or at the time the scan -- shortly after the scan was done?

**A. Shortly after the scan was done.**

Q. Okay. Now, what were -- according to this report, what was Dr. Hammond's impression or finding concerning the hernia?

**A. He said hiatal hernia is present. And, you know, we do something in the body of the report where we describe all the important features of the pathology that's going on in the patient. And then the impression we try to focus the clinician to what are the key features that we see here. And the second impression was hiatal hernia, post surgical change of the stomach.**

Q. Okay. Now, I anticipate that the defense radiology expert will offer testimony that there is not -- or will focus the testimony on the fact that this impression does not mention paraesophageal hernia. Is that your understanding from reading the expert designation?

MR. LUCCIA: Form.

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MR. HUGHES: Objection to form.

MR. PAINTER: Let me rephrase that. That's just a bad question.

BY MR. PAINTER:

Q. So this impression we're finding that Dr. Hammond made regarding a hiatal hernia, does that exclude any particular type of hiatal hernia or not?

**A. No. Because hiatal hernia is kind of the overarching term and you can have a sliding, paraesophageal, or mixed like Sonia had, a sliding and paraesophageal.**

Q. Got you. Let's move on to the next study which was, I believe, done the next day; is that correct?

**A. That's correct. So the surgery was on the 13th, the first upper was done on the 14th, the CT was done on the 15th, and another upper GI was done on the 16th.**

Q. Okay. And why would you do -- what would be the indication for ordering another upper GI at that point?

**A. Well, the only reason you order studies, you know, at this point is the patient is not doing well. And, you know, you haven't given me**

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**an answer, Mr. or Ms. Radiologist, and so let's study the patient again.**

Q. Okay. So let's look at the first image here. This is one of the images from the upper GI of August 16th, correct?

**A. That's correct.**

Q. Is -- in your opinion, is the hernia still present there?

**A. That's right. And we can see the hernia circled in the yellow oval. And as we see, the hernia is above the level of diaphragm.**

Q. Do you have an opinion as to whether or not the hernia reflected here is -- what is reflected is the same type of hernia as reflected on the other two images?

**A. Oh, it's the same.**

Q. Okay. Or the other two studies.

Let's go to Number 37, Slide 37. And what is this?

**A. Slide 37 this is another -- when you do an upper GI series or esophagram, you take multiple images, multiple pictures, and here we can see the esophagus. And there is the herniated stomach and there is the diaphragm. So again this tube, the esophagus, should be heading south of**

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**the diaphragm here, but here the esophagus is north as is the hiatal hernia.**

Q. Okay. What about in Slide 38, what does that show?

**A. Slide -- same thing again. Here we can see the hernia. And here's the diaphragm. So here we see the hiatal hernia, here we can see the stomach that's been shaved down because of the gastric sleeve procedure.**

Q. If -- if Ms. Thompson had not had a hernia at that point, where would you expect to see the esophagus and the stomach with regard to the diaphragm?

**A. Okay. The esophagus and stomach should be down -- the joining of the esophagus and stomach should be around this level.**

Q. Got you.

**A. Slightly beneath the diaphragm.**

Q. Okay. Let's move to Slide 39. Okay. Now, we'll go -- this is just -- what is this one?

**A. Okay. This shows the same thing. Here we see the hernia. Here is the stomach after you shaved it down for the gastric sleeve. Here is the duodenum, that's the first part of your small bowel. And then these arrows are the diaphragm.**

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Q. Okay. We're going to go over to next Number 40, which this is the radiology report by Dr. Roman Raju; is that correct?

**A. Right. He's the same fellow who read the first one.**

Q. And, again, what does the history say for his report of reading this upper GI?

**A. Gastric sleeve.**

Q. Does there -- is there any indication of Mrs. Thompson's history of hiatal hernia repair mentioned in this report?

**A. No.**

Q. Okay. And is there any mention of any hernia on this report?

**A. No, there is not.**

Q. Okay. Is that something that you would have mentioned?

**A. Yes, I would.**

Q. The fact that there is no mention in the history of a hernia, does that give any suggestion to you as to what the purpose of this study was?

**A. Again, when I see the history gastric sleeve, what I'm looking primarily for is a leak.**

Q. I understand. Now, let's go over to your next slide which is 41. This is a -- just shy of

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a month later; is that right?

**A. That's correct. So the first upper was done on 9/14 and so here's an upper GI --**

Q. Rather 8/14, right?

**A. 8/14, correct. And this was done almost a month later and this is the upper GI done on September 11th, 2013.**

Q. Okay. So let's go to Slide 42 which is -- tell the jury what this is.

**A. Okay. This looks very much like what we saw before. So here's the patient's heart. Here's Sonia's esophagus. Here is the hernia. And again these structures are above the diaphragm. And again the esophagus where it joins the stomach should be south of this structure, should be south of the diaphragm. All right.**

Q. Let's go to the next slide. This is just another image from that upper GI?

**A. Right. And again it shows the diaphragm and it shows the hernia. And here's the stomach that's been shaved down for the procedure.**

Q. Okay. Let's go to Slide 44. What is this?

**A. Boy, same thing. And again we can see the esophagus, the stomach, the diaphragm, and**

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**again these structures should be further south. They should be beneath the diaphragm.**

Q. And I think you have one more image and again these are representative images?

**A. Yes.**

Q. What is this one?

**A. Okay. This kind of shows the same thing. Here we can see the hernia and here we can see the diaphragm. And again these structures should be south at this point.**

Q. Okay. Let's go to Slide 46. And this is a radiology report by Dr. Frank Morello; is that correct?

**A. That's correct.**

Q. He's the radiologist that reviewed this upper GI?

**A. He probably performed it and reviewed it as well.**

Q. Okay. And what is Dr. Morello's impression or finding based on this?

**A. Okay. His impression was that we have a moderate sized paraesophageal hernia with partially obstructive changes within the hernia from the esophagus and exiting the hernia into the die -- subdiaphragmatic stomach.**

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12:22 Q. And so Dr. Morello, do you agree with his opinion?
12:22 **A. Yes, I do.**
12:22 Q. Okay. Let's go to the next slide, Slide 47. What do we have here?
12:22 **A. Okay. Actually I have both exams side by side, and so on this slide on the left I have the first upper that was done on August 14th and on the right side I have the upper GI that was done on September 11th and, boy, they look kind of similar.**
12:23 Q. Okay.
12:23 **A. The shape of the -- the herniated stomach and here we can see the diaphragm where I put my yellow arrow and here we can see the diaphragm where I put my yellow arrow.**
12:23 Q. Now, on the study on the right that was done on September 11th, 2013, this is the one where the radiologist referenced the hernia in the report, correct?
12:23 **A. Correct.**
12:23 Q. Now, the one on the left of August 14th, 2013, there was no hernia referenced in that report, correct?
12:23 **A. Correct. But, you know, you consider**

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**them pretty much the same, the appearance of the hernia.**
12:23 Q. Now, the day after the study on the left, there was -- which was August 15th, 2013, there was an abdominal CT; is that correct?
12:23 **A. Correct.**
12:23 Q. Tell the jury was the hernia mentioned -- was a hiatal hernia mentioned in that report on August 15th?
12:23 **A. Yes, it was.**
12:24 Q. Let's move on now to the next slide which is Slide 48. Now, this is an upper GI of September 16th; is that right?
12:24 **A. That's correct.**
12:24 Q. Now, what significantly in terms of surgical interventions happened just prior to this -- this upper GI?
12:24 **A. Okay. Ms. Thompson had surgery for gastric volvulus and repair of the paraesophageal hernia and lysis of adhesions on 9/13/13. So she -- patient had volvulus, had lysis of adhesions, that is fibrous tissue that you get after surgery, and then repair of a paraesophageal hernia.**
12:24 Q. And Dr. Leiva is the surgeon, the primary

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surgeon who took her back to surgery on
12:24 September 13th; is that correct?
12:24 **A. I believe so.**
12:24 Q. Now, this is an upper GI then we're getting ready to look at that is three days after
12:25 Dr. Leiva's second surgery, correct?
12:25 **A. That's correct.**
12:25 Q. Okay. So let's look at the first image and what does that show?
12:25 **A. Okay. So the first image shows, you know, now here we can see the esophagus and the esophagus is going south of the diaphragm as it should. So here is, you know, the level of the diaphragm. And so that's good. You know, here we can see the esophagus, it's going further south and where it's joining the stomach, we can see it south of the diaphragm so that's good.**
12:25 Q. Now, do you see anything else that's significant upon this study?
12:25 **A. Okay. All right. But on this one you can see there is -- here is the esophagus and here we're starting the stomach. But here we're -- we kind of see an acute angle here. So the esophagus and stomach are going like that and then zoop, it makes, you know, an abrupt turn. And the GI**

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**tract, you don't like these acute angles, you know, these narrow angles. Because it's hard for food and other stuff to get through that. So, you know, we have repaired the -- the hernia has been repaired, but here we see that this kind of acute angle here. And again, food and water does not like to make this 90 degree turn.**
12:26 Q. Understood. Now, let's go to the next slide which was 50. So now we're -- this is another upper GI and this is, what, about 11 days after the second surgery by Dr. Leiva?
12:26 **A. That's correct.**
12:26 Q. Okay. And what do we see on Slide 51?
12:26 **A. Okay. On the left we can see the GI study from September 16th and then on the left we can see the GI study --**
12:26 Q. On the right?
12:26 **A. I'm sorry. On the right. Radiologic left.**
**Okay. And so here you can see things were nicely flowing from the esophagus into the stomach, but here it's getting a little narrow at that point.**
12:26 Q. Okay. And that's -- what area is that, that's the distal esophagus?

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**A. No, distal esophagus and proximal stomach and again we can see this, you know, acute angle. You know, it's got to go zoop, zoop, and stu -- food doesn't like doing stuff like that.**

Q. And what would be significant about having a narrowing like that exactly?

**A. Well -- Okay. Well, when you have a narrowing like that or an acute angle, it's tough for food and liquid to get through there.**

Q. And let's move on to Slide 52. We see here that now, what is this, 14 days, two weeks after Dr. Leiva's second surgery on Mrs. Thompson. We see -- what is this? UGI stent insertion?

**A. Okay. So when you have the stricture, you know, if you -- a narrowing of your stomach or even of your colon, rather than bringing the patient back to the emerg -- the operating room, you can put in a stent to kind of open things up and to let the food pass through it. And so that's what they did for Mrs. Thompson.**

Q. And what was the status of, if you're aware of this, of Mr. Thompson's nutritional status at the time of the stent placement?

**A. As I understand that, you know, she was losing weight and she had low protein and so her**

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**nutritional status was not good and I think that's probably one of the reasons they put in a stent is to help her, you know, the food pass through.**

Q. Okay. What's Slide 53?

**A. Okay. No, I certainly don't put these in, but this is a stent and here is -- in a different patient, here is the esophagus and here is the stent being put by a narrowing or a stricture in the esophagus. And so that's just an example what it looks like.**

Q. Okay. And you're familiar with stents in general through your radiology training?

**A. Yes.**

Q. And this is a fair depiction of a stent placement?

**A. That's correct. I must say interventional radiologists do put these in as well.**

Q. I understand.

**A. But I don't do that.**

Q. Let's move to Slide 54 which this is now one month to the day from Dr. Leiva's second surgery; is that correct?

**A. Correct.**

Q. Okay. Sorry for getting the dates

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confusing here.

And so what we see here is a chest X-ray; is that right?

**A. That's correct.**

Q. Now, let's look at the next slide. What does that show?

**A. Okay. So the first thing, this is a typical chest X-ray. Here is the heart. Here is the diaphragm. These are the lungs. And you can see the ribs, patient's right shoulder and left shoulder. And here we can see that metallic stent down here and that's -- it looks like -- looks like on the picture. And then because Sonia was not getting adequate nutrition she was being fed, you know, with -- in part intravenously and this is called a PICC line, a peripheral catheter that you can put all kind of goodies in to help your nutrition. And so, you know, you put it in the arm and here we see it going up towards the heart. This little white line. And that's the PICC line.**

Q. Understood. Let's move on to Slide 56 and this is an upper GI, but there was --

**A. Right.**

Q. -- another surgery. Can you tell us about that?

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**A. Right. Okay. On 10/23/13, Sonia underwent her third surgery and that was a partial gastrectomy where they removed more of her stomach. Lysis of adhesions, that is, you know, when you get surgery, you know, you get fibrotic tissue and so -- and scar tissue to do that, to open that up. And then she also had a different type of surgery, bypass surgery which is called Roux-en-Y surgery.**

Q. Now, generally speaking, a Roux-en-Y bypass, how does that alter the patient's anatomy?

**A. Okay. Well, actually rather dramatically. First of all -- okay. Can I go to an earlier slide?**

Q. Yes. Sure. Sure.

**A. All right. So when you do a Roux-en-Y gastric bypass surgery, you bring your stomach to a small little pouch of stomach. Then that pouch of the stomach is hooked to the small bowel -- hooked to the small bowel. Then all the juices that come from your liver and your pancreas that you need for digestion come through a -- you swing a different loop over and you join up the small bowel there. So you have a little pouch of stomach, it's hooked to the small bowel. Then you**

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**got another loop of small bowel draining your liver, your bile, and your pancreas and they come together.**

Q. Okay. So let's go back from Slide 49 to Slide 56. One more. And then let's -- you have a representative image, a few images from that upper GI study that was done the day after the Roux-en-Y surgery, correct?

**A. That's correct.**

Q. Tell us what Slide 57 shows.

**A. Okay. This is from the upper GI study that was done on October 24th, 2013. And here we can see the heart and here we can see the esophagus and esophagus is south of the diaphragm so that's good. And here there is a little bitty gastric pouch there and here the stomach is hooked to the small bowel. And that's --**

Q. Okay. We can go ahead to go to -- okay.

Did you have anything else on Slide 57?

Let's go to the next one. What does Slide 58 shows?

**A. Okay. Slide 58 here is your little gastric pouch and here we can see the contrast, the stuff you drink, exit the little pouch and go**

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**into the small bowel.**

Q. Let's go to slide -- the next slide?

**A. 59 shows the same thing. Here we can see the little gastric pouch hooking up to the small bowel.**

Q. Let's go to Slide 60, another representative slide. What does it show?

**A. Okay. So this is -- the surgeon left in the surgical drain and here's a little gastric pouch and here's the small bowel that it's hooked to.**

Q. What is the purpose of the surgical drain?

**A. Because the -- Sonia got a postoperative infection and there was some fluid around the spleen.**

Q. Okay. And the drain is to --

**A. Drain the pus.**

Q. Get rid of the fluid and the pus?

**A. Yeah. Yeah.**

Q. What about the next slide, Slide 61, what does this show?

**A. Slide 61 kind of shows the same thing. Here we can see the drain around the spleen and then it shows the -- the small bowel that's hooked**

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**to the little gastric pouch.**

Q. Okay.

**A. And similarly on --**

Q. Slide 62?

**A. -- Slide 62, kind of the same thing. So here is the surgical drain because there is some fluid and pus up there. And then we can see a little gastric pouch and hooked up to the small bowel.**

Q. And let's go next to the next slide, Slide 63. So we see this is -- September, October, November, December -- almost four months after the first surgery by the defendants; is that correct?

**A. That's correct.**

Q. What is -- this says PICC line insertion. What is this PICC line insertion about?

**A. Okay. It's like the PICC line we saw before. You know, when your nutrition is bad, you know, that your gut isn't functioning well, you know, you're losing weight, you're losing protein, you just can't get enough nutrients. So here you feed the patient through the PICC line. And so here we can see on the prior study it was on the right side -- left side. Here it's coming from**

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**her right arm and going right towards the heart. And so she's getting protein and other nutrients through the IV.**

Q. So the PICC line is to address malnutrition or something else?

**A. In this case it's due to malnutrition, but in some people who've got cancer you give your chemotherapy agent through that. If some people have a rip roaring infection that's going -- antibiotics for a long time, you do that as well. But in her case it was for giving her nutrition.**

Q. Okay. We're almost finished here, Doctor. Let's go to Slide 65. And this is a chest X-ray that's done just over eight months after the first procedure; is that correct?

**A. I think so.**

Q. The first surgery, I mean the bariatric surgery by the defendants. And this is a chest -- is that a chest X-ray?

**A. Right. This is a chest X-ray and they had to change the side of her PICC line and so the first time it was on this side. Then they changed it over to her right side. And now they put in a new PICC line on her left side. So again she wasn't getting enough nutrition so she had to get**

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**some through her veins.**

Q. Did you say she was not getting enough --

**A. No, the reason you have a PICC line this long postoperatively is because you're not getting enough nutrition.**

MR. PAINTER: Dr. Gore, I thank you for your testimony today and I pass the witness.

EXAMINATION

BY MR. LUCCIA:

Q. Good morning, Dr. Gore.

**A. Good morning.**

Q. I'm going to figure out how I pin this to myself. My name's Frank Luccia. I represent Dr. Bina. I have a little bit of follow-up for you, not too much.

I'm looking at your report which has been marked as Exhibit --

**A. 4.**

Q. -- 4, and I'm looking at the X-rays that you list here that you've had the opportunity to look at to help you form your opinions in this case. They're numbered 1 through 9?

**A. Right.**

Q. It appears to me that there are two studies that predate the August 13th, 2013

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surgery. There was a CT scan on April the 4th of 2013 and abdominal ultrasound on April the 4th of 2013?

**A. Correct.**

Q. Okay. Did you have an opportunity to review those two imaging studies?

**A. Yes, I did.**

Q. Okay. And the CT scans, we've talked about several CT scans that were done postoperatively, correct?

**A. Right.**

Q. And you've talked to us today about the hernia that you're able to see on those postoperative CT scans, correct?

**A. Right.**

Q. So we know that CT scanning is one way that a radiologist can identify a hernia if there is one?

**A. That's right.**

Q. Okay. In your review of the April 2013 CT scan done four months before the surgery at issue, do you see any evidence of a hernia?

**A. I looked a long time ago. I don't recall.**

Q. Is there any way for you to take a look

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at it?

**A. Not unless you have the disk. I have some disks. Wait a second. I don't know what's on what. All right. Should we go off the record while we do this?**

MR. LUCCIA: Sure.

THE VIDEOGRAPHER: Okay. Going off the record at 12:38 p.m.

(Discussion held off the record.)

THE VIDEOGRAPHER: Going back on the record at 12:45 p.m.

BY MR. LUCCIA:

Q. Doctor, we took a short break. During that break, did you have an opportunity to take a look at the April 4, 2013 CT scan?

**A. Yes, I did.**

Q. And that's the scan that was done approximately four months prior to the gastric sleeve procedure?

**A. That's right.**

Q. On that April 4th, 2013 scan, are you able to see a hernia?

**A. Yes, I am.**

Q. And can you tell us what kind of hernia you see on that image?

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**A. From that one it just looks like a hiatal hernia, but again, I don't see the reformatted images so I can just say hiatal hernia, but I can't specify more specifically.**

Q. And by hiatal hernia, you mean a sliding hernia?

**A. Sliding -- sliding for sure. Could there be a paraesophageal component? It's possible.**

Q. So all you're able to tell us in reasonable medical probability is that there appears to be a sliding hernia, a Type I hernia, on the CT images of April the 4th, 2013; am I correct?

**A. Okay. It's either a Type I or a Type III where you have a combined. It's not just isolated paraesophageal.**

Q. But am I -- I thought I heard you say possibly so I -- I need to know what you're able to say in reasonable medical probability.

**A. Okay.**

Q. So are you able to tell us in reasonable medical probability whether this is a Type I, Type III, or your -- or neither?

MR. PAINTER: Form.

BY THE WITNESS:

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**A. It -- no, it is a hiatal hernia. I think, you know, common things occur commonly so it would be Type I.**

Q. And you understand that at the time of the surgery performed by Dr. Leiva and which my client assisted, they found what they believed to be a Type I hernia?

**A. Yes.**

Q. In your report, which is marked as Exhibit 4, you tell us that the upper GI examination obtained on April the 14th shows post-surgical changes from a gastric sleeve and attempted hiatal hernia repair. Your slides numbered 14, 15, 16, and 17 are from that imaging. Can you tell us what it is you're seeing on those slides that allows you to know that there was an attempted hiatal hernia repair?

**A. Just from the history. Or just from reading the medical record.**

Q. Okay. So when you say that the images show post-surgical changes of a gastric sleeve and attempted hiatal hernia repair, you're not intending to communicate that the images show that?

**A. No. The images show that there is -- I**

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**know there was a hiatal hernia repair and it didn't work and so there is a persistent hernia there.**

Q. Okay. Can you go to your Slide Number 3?

**A. Okay.**

Q. Okay. You told us that this is a fair representation of what Ms. Thompson's stomach would have looked like after the gastric sleeve procedure. Did I understand that correctly?

**A. No, I'm saying this is what a typical patient looks after gastric sleeve procedure, but not one who had a hernia repair at the same time.**

Q. Okay. And tell -- can you use this image to tell us what would be different in the appearance of what you've marked as the new side if they had a hiatal hernia repair performed at the same time as the gastric sleeve?

**A. If there was a hiatal hernia repair, I should see some deformity here from a wrap. You know, they kind of wrap the stomach around the esophagus and bring the hernia down. So I would expect to see some deformity underneath the diaphragm at this point in the gastric sleeve.**

Q. And what would the deformity look like?

**A. It would look like -- okay. So here's my**

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**esophagus coming down. And here's my stomach wrapped around it. So it would be looking -- a tube going through a wrap.**

Q. And are you able to see that on any of the post-surgical images?

**A. Not beneath the diaphragm, no.**

Q. Is that the kind of -- I'm sorry. Not below the diaphragm?

**A. I don't see anything like that below the diaphragm.**

Q. Are you able to see that below the diaphragm once Dr. Leiva does the hernia repair on September the 13th?

**A. Take a look. Sorry.**

Q. No problem.

**A. Yes, I see part of that deformity at this point.**

Q. And so is it that little indentation that you're seeing?

**A. I think that's part of the wrap, yes. A part of the hernia repair.**

Q. Okay. But on the earlier images, that little deformity is above the diaphragm?

**A. A deformity is above the diaphragm, correct.**

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Q. Right. After that hernia repair, the deformity is below the diaphragm?

**A. Correct.**

Q. Okay. I'll write that down. We'll get back to that.

Okay. Can you go to Slide Number 5?

**A. Let's see. There must be a faster way. Let's see. Should I go to -- all right. I guess I'll have to page through each one.**

MR. PAINTER: Doctor, you know what you might want to do is just use the -- do you have the exhibit?

THE WITNESS: Oh, okay.

MR. PAINTER: That might be faster depending on the question.

THE WITNESS: Just in case.

MR. PAINTER: Okay.

BY MR. LUCCIA:

Q. Okay. This is the slide that you said shows us the various types of hernias, correct?

**A. That's right.**

Q. Now, these are all examples of what the hernias look like for patients with a normal stomach?

**A. Right. Patients who have not had a**

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**gastric sleeve.**

Q. Right. Have you brought with you, or are you even aware of a similar type of drawing that would show us what the -- what the different types of hernia look like in a patient who has had a gastric sleeve?

**A. I haven't seen diagrams like that. I can look for them and, you know, if I bring it to trial, we'll send it to you beforehand.**

Q. Okay. And if you go to the next slide, slide Number 6. Now this was -- this is a slide that's been -- did you put the title up here, importance of hiatal hernia?

**A. No, I got this from the Internet actually.**

Q. Okay. Now, the hernia that they're showing there is a Type I sliding hernia?

**A. The one they're showing is a Type I.**

Q. Okay. Which, based on the images we have, is more likely than not the type she had at the time of her gastric sleeve?

**A. That would -- yeah, common things occur commonly so Type I is more common than Type III.**

Q. Okay. If you could now go to Slide 21. Okay. This is the CT scan that was done two days

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after the operation, right?

**A. That's right.**

Q. And that yellow circle you have there is the circle around the portion of the stomach that is above the diaphragm --

**A. That's correct.**

Q. -- correct?

Okay. Now, I notice in this picture that the spine -- can you point to the vertebrae of the spine?

**A. Mm-hmm.**

Q. They are very white?

**A. Correct.**

Q. And I notice on the edges of the picture that the ribs -- can you point to some of those?

**A. Here are the ribs.**

Q. Those are very white?

**A. Correct.**

Q. Okay. And when we look at the lungs, it's very black?

**A. Right.**

Q. Okay. I'm guessing that what this means is that really hard things show up as white, really dense things show up white, and non-dense things show up black?

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**A. Right. So bone is white, air is black, soft tissue is kind of gray.**

Q. Right.

**A. And fat is somewhere between gray and fat.**

Q. And if we look at that portion of the stomach that you say is paraesophageal -- next to the esophagus, right?

**A. Yes.**

Q. There is a white stripe in that piece of the stomach. Do you see that?

**A. Correct. Yes, I do.**

Q. And it's very white?

**A. Correct.**

Q. That means it's very hard, very dense?

**A. Correct.**

Q. That is the staple line?

**A. It may be the staple line or it could be -- remember the -- I didn't talk about this. The patient was given some barium to drink, and when you -- or contrast. And when you give contrast to drink, that can be white as well. So I'm not sure if it's the staple line or the contrast.**

Q. Well, we know it's a nice straight line?

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**A. Correct.**

Q. And if we go to the next image, 22?

**A. Okay.**

Q. We still have a nice straight line?

**A. Yes.**

Q. And if we go to the next image, Number 23?

**A. Same.**

Q. 23. Right.

So, can you tell us to a reasonable medical probability what we're seeing in that portion of the stomach that is the paraesophageal hernia we are seeing the staple line?

**A. I'm sorry. I don't understand the question.**

Q. Sure. In reasonable probability, the reason we're seeing that white line in the paraesophageal hernia is because the staple line is in that portion of the stomach?

**A. It's either the staple line or some of that dense contrast that we gave.**

Q. And if we go to Image 29, do we see that staple line again?

**A. Yes, we do. A staple line or the contrast.**

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Q. Okay. Is it within the realm of your expertise to know that there is no way to place a staple line above the diaphragm if one is performing a laparoscopic gastric sleeve procedure?

**A. From speaking to surgeons, you know, they can put their instruments from the belly up north and staple it up north.**

Q. Okay.

**A. Above the diaphragm. That's my understanding.**

Q. Okay.

**A. But that would probably be better directed towards a surgeon.**

Q. That's beyond your expertise, fair?

**A. Correct.**

Q. Based on your understanding of the way this procedure is performed, do you -- well, I guess I should ask, do you have an understanding that the way this gastric sleeve procedure is performed is that the stomach is mobilized below the diaphragm and the staple line is placed?

**A. I would assume so, but again I would defer to a surgeon on how to do it.**

Q. The fact that the staple line is seen in

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these images above the diaphragm, in your experience as a radiologist, does that suggest to you that following some time after the gastric sleeve was performed that the hernia developed?

MR. PAINTER: Objection. Form.

BY THE WITNESS:

**A. I don't think I can answer that.**

Q. Because you don't have enough expertise as a surgeon?

**A. That's correct.**

Q. You mentioned the deformity in the esophagus that we see as a result of the wrap that's used during the repair of a sliding hernia?

**A. Correct.**

Q. And you told us that in these images, that deformity is above the diaphragm?

**A. No, I think I was talking about the deformity of the esophagus was beneath the diaphragm. Let's see. It was the later examination.**

Q. Right. I understood that after Dr. Leiva repaired the hernia in September, the deformity is clearly below the diaphragm?

**A. Correct.**

Q. Before Dr. Leiva's repair of the hernia

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on September 13th, the deformity is above the diaphragm?

**A. That's correct.**

Q. Right. Now, there is no way that -- that Dr. Leiva could have placed the band on the esophagus above the diaphragm?

MR. PAINTER: Objection to form.

BY MR. LUCCIA:

Q. True?

**A. Again, I would defer to a surgeon there, but, you know, sometimes they go through the belly and they can do stuff down south in the esophagus. But again I would ask a surgeon.**

Q. I guess I'm -- you're a specialist in GI imaging, true?

**A. I hope so.**

Q. So I guess what I'm trying to figure out is, in your business, I mean does it happen to you that you look at images like this and say I know that the patient had a gastric sleeve, I know that the patient had a sliding hernia repair. I am now seeing what looks like a staple line and indications of a band above the diaphragm?

**A. Yeah, I understand.**

Q. Does that happen to you?

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**A. Oh, yes. Oh, where -- no, where I can see -- and that's why I said surgeons will sometimes go through the hiatus to do things to the southern or distal part of the esophagus.**

Q. But have you ever then looked at that information and said that it appears to me that since you performed the gastric band, this patient appears to have developed a hernia?

**A. I don't know if I said that.**

Q. In this case, are you able to look at any of these images and tell us when the hernia developed?

**A. Well, there was a hernia preoperatively because we saw that in April. And then I see the hernia the following day.**

Q. Well, you told us that you saw what you can state in reasonable medical probability is probably a sliding hernia?

**A. Beforehand.**

Q. Beforehand. Now, can you tell us when this paraesophageal hernia developed based on anything you see in these pictures?

**A. Sometime between April and the time the upper GI exam was done, but the surgeon would not leave a paraesophageal hernia there. He would**

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**have repaired it.**

Q. Let me follow up on that. I want to make sure I understand what you're saying. Are you telling me you can't imagine that the surgeons would have left a paraesophageal hernia there, Drs. Leiva and Bina, if it had been there at the time of their procedure?

**A. It would -- again, I'm not a surgeon, but I would think that, you know, that's part of their job is to reduce the hernia.**

Q. And the fact that the staple line is above the diaphragm and the fact that the band to repair the sliding hernia is above the diaphragm, more likely than not suggests to us that those structures -- that stomach, that staple, and that bands were below the diaphragm at the time the staples were placed and the band was placed?

MR. PAINTER: Objection. Form.

BY THE WITNESS:

**A. I think I'd have to ask a surgeon that question.**

Q. Part of the reason that I understand you're calling this a paraesophageal hernia is that the esophagus comes down and then we appear to have like a 90 degree turn. Right there. I

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mean that image is good enough.

**A. But actually I can show on the -- okay. So what we're having is -- I think we've got both sliding and paraesophageal component here.**

Q. In fairness, you know, these insets, they don't fairly and accurately represent what's going on with Ms. Thompson because those insets don't show a patient post gastric sleeve?

**A. You're quite right.**

Q. Okay. But I mean I -- I see what you're looking at here and the esophagus comes down. Now, where is the G.E. junction where the stomach meets the esophagus?

**A. Okay. The stomach meets the esophagus up here.**

Q. Okay. Right. Okay. So the esophagus ends, the stomach starts, and then we have almost a 90 -- what appears to be a 90 degree turn, fair? You called it an acute angle?

**A. No, that was actually after the second surgery. I don't see an acute angle here.**

Q. Okay.

**A. All right.**

Q. Let me see if I understand. So what you're seeing here is --

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**A. Here is the esophagus.**

Q. Right. And you're seeing --

**A. Here is the gastroesophageal junction and here the angle is kind of obtuse, it's not acute, and here we can see the contrast flowing south.**

Q. Maybe I misunderstood. I thought the fact that you were seeing that stomach to the right of the esophagus is what made you believe it was paraesophageal?

**A. To the right on our image, but actually to the patient's left. That's part of it, correct.**

Q. Okay. Now, what we know is once Dr. Leiva takes the patient back and pulls all of that below the diaphragm, it still makes that acute angle?

**A. No. Here we can see this angle is kind of maybe it's 130 degrees and let's look at the angle after the next surgery.**

Q. Which is on Slides 49 -- 49?

**A. Okay. So the angle before was this way and then it went down in this direction.**

Q. Right.

**A. But now the angle is this way and it goes back up. So the angle's acute. Before it was**

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**obtuse. It was wide. Now it's narrow.**

Q. And, again, it may be outside of your expertise. Are you going to be expressing an opinion about why we're seeing this acute angle after the hernia is reduced?

**A. I would defer to a surgeon about that.**

Q. I mean if we take that yellow line where you -- that's the diaphragmatic --

**A. Right.**

Q. -- line. I mean and we pull that stomach back up, we'd see the same thing we saw preoperatively where that stomach, that little bit of the stomach is next to the esophagus? If you move that --

**A. I don't understand the question.**

Q. Yeah, sure. Where the esophagus goes through that yellow line?

**A. Yes.**

Q. That's the hiatus?

**A. Correct.**

Q. That's a hole in the diaphragm?

**A. A normal hole.**

Q. Right. If I pulled that esophagus back up toward the patient's mouth and I pulled, I would get that bit of the stomach and that acute

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part in the hole, right?
**A. Assuming the esophagus was -- and stomach were long enough and assuming when you're pulling you didn't open up the sutures.**
Q. Right. And I guess that's what I'm trying to figure out, is -- is it -- do you think that if you pulled that back up, you could return the anatomy to what we see before Dr. Leiva's hernia repair?
**A. That I don't know.**
Q. Okay. Have you seen this before in your experience?
**A. You mean this type of picture?**
Q. Yes.
**A. Yes.**
Q. And have you done any investigation to figure out why it is a patient's stomach might look like that?
**A. No.**
Q. Never talked to anybody, never looked it up in a book?
**A. No.**
Q. So I presume at the time of trial you'll be expressing no opinion as to why it looks that way?

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**A. Correct.**
Q. You've talked to us about your opinions regarding the two radiology studies that were done the day after surgery and the second day after surgery, right?
**A. Right. There were three studies postoperatively: Upper GI, then CT, and then another upper GI.**
Q. And as I understand it, on all of those you can see a paraesoph -- what you believe to be a paraesophageal hernia?
**A. That's correct.**
Q. And you understand that none of the radiologists who interpreted those films reported a paraesophageal hernia?
**A. One said a hernia and then that would come both sliding, paraesophageal, or para -- combined paraesophageal and sliding.**
Q. Am I correct that none of those radiologists reported the paraesophageal hernia?
MR. PAINTER: Form.
BY THE WITNESS:
**A. No one used the word paraesophageal.**
Q. Are you critical of the radiologists for failing to communicate that there is a

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paraesophageal hernia in the first imaging study?
**A. No.**
Q. You believe it was within the standard of care for him to not mention that there was a hernia?
**A. Because in the first study what you're looking for is a leak. I would have mentioned it.**
Q. So this is one of those areas in which radiologists might report differently. It's not saying somebody's right and somebody's wrong?
**A. Right. There -- the hernia is there, but some radiologists, you know, just answer the question is there a leak or not and some kind of would be more expansive in their reports.**
Q. And, as I understand it, you're okay with the fact that the radiologist reading the CT scan said hernia whereas you would have said paraesophageal hernia?
**A. Yeah, the radiologist hiatal hernia, that's fine.**
Q. I presume you're not going to be expressing any opinions about my client, Dr. Bina, the assistant surgeon during the original gastric sleeve procedure, am I correct?
**A. That's correct.**

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MR. LUCCIA: Okay. I think that's all the questions I have for you, sir. I appreciate your patience.
MR. PAINTER: Do you have anything else you want at this point?
MR. HUGHES: Not at this point.
MR. PAINTER: I'm going to take a short break. I want to look at some notes.
THE VIDEOGRAPHER: Okay. Going off the record at 1:11.
(Discussion held off the record.)
THE VIDEOGRAPHER: Back on the record at 1:19.
FURTHER EXAMINATION
BY MR. PAINTER:
Q. Doctor, I want you to go back one slide to Slide 4 and I want you to describe these -- what we're seeing here just generally speaking?
**A. Okay. All right. This is a person who's got an intact stomach and all three of these patients have an intact stomach. What it does depict what's going up above the diaphragm and so if you were to have a gastric sleeve procedure, what's going up above the diaphragm would still be the same. You just have a skinnier stomach.**
Q. Okay. And so in these images, you have a

full stomach below the diaphragm, correct?

**A. Correct.**

Q. Above the diaphragm would be a fair and accurate representation of the type of hernias indicated whether you had a gastric sleeve or not?

**A. That's correct. The only difference is that, you know, you'd have a skinnier stomach because of the sleeve. What's going on up north is the same.**

Q. Let's go to Slide 5. And if you could just identify what this is generally?

**A. Okay. So here we have all patients who have their intact stomach, but here we can see the diaphragm. Here is a sliding hiatal hernia and if you had a gastric sleeve, it would be all the same, but it would be cutting out about three-quarters of your stomach along here. Same thing here, you'd be cutting out three-quarters of your stomach, but what's going on above the diaphragm would be the same. And same thing on Type number III, what's going on up north is the same above the diaphragm, but stomach would be skinnier because you remove a lot of it.**

Q. Okay. So we're looking at the -- let's just look at Type I and Type III hernias reflected



on this imaging -- rather on these illustrations. Are they fair and accurate depictions of the type of hernias reflected whether or not there is a normal stomach intact or you have a gastric sleeve above the diaphragm?

**A. Above the diaphragm they would be fair and accurate.**

MR. PAINTER: Okay. Thank you. I pass the witness.

MR. HUGHES: One more.

THE WITNESS: Yes, sir.

FURTHER EXAMINATION

BY MR. HUGHES:

Q. So if we look at Type III, right?

**A. Correct.**

Q. And we did a gastric sleeve?

**A. Yes.**

Q. The staple line would be below the diaphragm? If we left that Type III hernia and performed a gastric sleeve, the staple line would be below the diaphragm?

**A. I defer to a surgeon, but I would think it should be.**

Q. Right.

**A. But I defer to a surgeon.**



Q. So if we see a staple line above the diaphragm postoperatively, then that suggests that that Type III hernia developed after the gastric sleeve was performed?

**A. I don't know if I can say that. Again I would defer to a surgeon.**

MR. HUGHES: Thank you, sir.

MR. PAINTER: That's it. So I have --

THE VIDEOGRAPHER: Going off the record at 1:23.

(WITNESS EXCUSED.)



CHANGES AND SIGNATURE

| PAGE LINE | CHANGE | REASON |
|---|---|---|
| | | |

I, RICHARD GORE, M.D., have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted above.

_____
RICHARD GORE, M.D.

THE STATE OF _____)
COUNTY OF _____)

Before me, _____, on this day personally appeared RICHARD GORE, M.D., known to me (or proved to me under oath or through _____) (description or identity card or other document) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, _____.

_____
NOTARY PUBLIC IN AND FOR
THE STATE OF _____
MY COMMISSION EXPIRES:
_____



IN THE DISTRICT COURT OF
HARRIS COUNTY, OF TEXAS
295TH JUDICIAL DISTRICT

SONIA THOMPSON, )
)
Plaintiff, )
)
v. ) No. 2015-63735
)
JORGE LEIVA, M.D., SAID BINA, )
M.D., and ZIAD AMR, M.D., )
)
Defendants. )

REPORTER'S CERTIFICATION
DEPOSITION OF
RICHARD GORE, M.D., F.A.C.G., F.A.C.P., F.A.C.R., A.G.A.F,
JANUARY 30, 2017

I, JOAN M. BURKE, Certified Shorthand Reporter and Registered Professional Reporter in and for the State of Illinois, hereby certify to the following:

That the witness, RICHARD GORE, M.D., was duly sworn by the officer and that the transcript of the oral deposition is a true record of the testimony given by the witness;

That the deposition transcript was submitted on _____, to the witness or to the attorney for the witness for examination, signature and return to me by _____;

That the amount of time used by each party at the deposition is as follows:

Mr. Matthew Hughes - 33 minutes
Mr. Robert Painter - 55 minutes
Mr. Frank Luccia - 28 minutes

That pursuant to information given to the deposition officer at the time said testimony was taken, the following includes counsel for all parties of record:

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I further certify that I am neither counsel for, related to, nor employed by any of the parties or attorneys in the action in which this proceeding was taken, and further that I am not financially or otherwise interested in the outcome of the action.

Further certification requirements Pursuant to Rule 203 of TRCP will be certified to after they have occurred.

Certified to by me this 9th day of February, 2017.

_____
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FURTHER CERTIFICATION UNDER RULE 203 TRCP

The original deposition/signature page was/was not returned to the deposition officer on _____;

If returned, the attached Changes and Signature page contains any changes and the reasons therefor;

If returned, the original deposition was delivered to _____, Custodial Attorney;

That $_____ is the deposition officer's charges to the Defendant for preparing the original deposition transcript and any copies of exhibits;

That the deposition was delivered in accordance with Rule 203.3, and that a copy of this certificate was served on all parties shown herein on _____ and filed with the Clerk.

Certified to by me this _____ day of _____, _____.

_____

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