STATE OF ILLINOIS
IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT
COUNTY OF MCLEAN

NATHAN CAIN, Independent Administrator of the Estate of CANDICE CAIN, deceased,
Plaintiff,
vs.) No. 14 L 28
THOMAS DeWEERT and DIGESTIVE DISEASE CONSULTANTS, LTD.,
Defendants.

The discovery deposition of RICHARD M. GORE, M.D. taken in the above-entitled cause, before Athanasia Mourgelas, Certified Shorthand Reporter, a notary public of Cook County, Illinois, on August 4, 2017, at the hour of 10:11 o'clock a.m., at 2100 Pfingsten Road, Conference Room D, Glenview, Illinois, pursuant to notice.

Reported by: Athanasia Mourgelas, CSR
License No. 084-004329

APPEARANCES:

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ALSO PRESENT: Thomas DeWeert, M.D.

I N D E X

WITNESS	EXAMINATION
RICHARD M. GORE, M.D.	
By Mr. Brandt	4

E X H I B I T S

NUMBER	MARKED FOR ID
DR. GORE Deposition	
Exhibit No. 1	115
Exhibit No. 2	115

(Whereupon, the deposition commenced at 10:11 a.m.)
(Witness sworn.)

MR. BRANDT: Let the record reflect that this is the discovery deposition of Dr. Rich M. Gore taken pursuant to notice, the applicable Supreme Court Rules.

RICHARD M. GORE, M.D.,
having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. BRANDT:

Q. Good morning, Dr. Gore. We met earlier. You brought with you, in essence, your file.

Can you just catalog for us on the record what you have? I know you have a lot of images. Let me just ask you a question, we were given before the deposition a -- what was described as a PowerPoint that had a number of images on there.

Are those the images that you have in front of you in disk form?

A. That's correct. And I have some additional images as well as and some additional demonstratives since you were sent the e-mail or

the sent the --
Q. Disk?
A. -- disk, right.
Q. Okay. So in any event, I have, in essence, all the disks that you have in front of you on one disk --
A. Right.
Q. -- that was sent; is that right?
A. Oh, the key images from each of the -- you know, because there's thousands and thousands of images.
Q. Right. Okay. What you put -- what are on disk that we received in response to the discovery or as part of the discovery disclosure, were those images that you thought were important to your testimony, is that right --
A. That's right.
Q. -- is that a good way to describe it?
You also have some notes regarding a couple of depositions. Which depositions did you have notes on?
A. One of Dr. Jay Woodland, J-A-Y, W-O-O-D-L-A-N-D and a Dr. Juliette, J-U-L-I-E-T-T-E, Scantlebury,

S-C-A-N-T-L-E-B-U-R-Y.
Q. Okay. And we talked about before the deposition that we would take a break and make copies of those and we can attach those to the deposition and we'll mark them later. Is that fine with you?
A. That's fine.
Q. Did you re-read any other depositions in this case?
A. No.
Q. Okay. Did you look at any other materials in this case besides the images? In other words, did you look at medical records?
A. I looked briefly but a long time ago, I haven't looked at the medical records in over a year, but I do look at the radiology reports as well.
Q. Okay. And would that be all the radiology reports for the images that you have on disk in front of you or just some?
A. I think the majority of them. I don't know each one. I didn't go and check.
Q. With respect to the reports themselves, did you have -- or do you have any opinions that

the reports were inaccurate, the radiology reports were inaccurate?
A. Boy, there were tons of reports. None that come to mind.
Q. None that you're going to testify here today about; is that right?
A. That there was a deviation of the standard of care, no.
Q. No, or just that you had a disagreement with the findings. Not that there was necessarily a deviation but that there was a disagreement with the findings by the radiologist?
A. Not that comes to mind now.
Q. Okay. With respect to any other medical records, did you look at operative notes? Did you look at procedure notes? What else did you look at?
A. Yes. You know, those -- you know, I didn't look at nursing notes but I would look at, you know, operative reports, radiology reports, interventional radiology reports. But that's been a while ago.
Q. Okay. Are all those records here in front of you?

A. They're on the CD.
MR. BRANDT: Okay. And I'll just ask for a copy of that.
MR. GINZKEY: A copy of what?
MR. BRANDT: The medical records that you sent him on disk.
MR. GINZKEY: Yes.
BY MR. BRANDT:
Q. Okay. Any other materials that you looked at? I know that you prepared -- did you prepare the PowerPoint presentation?
A. Yes.
Q. Any other documents that you either created or looked at in preparation for your testimony here today?
A. No.
Q. Did you look at any textbooks? It looks like you brought the textbook of Gastroenterology -- Gastrointestinal Radiology; is that right?
A. That's correct.
Q. And that's a book that bears your name; is that right?
A. That's correct.
Q. And is this the current edition that we

have here?
A. Yes. And now we're working on a fifth edition.
Q. This is the fourth edition; is that right?
A. That's correct.
Q. And what was the publication date of that?
A. This was 2015.
Q. Okay. Is there something in the textbook that you're going to refer to in this deposition or trial?
A. No.
Q. Okay. Is there anything in the textbook that discusses the issues that you're going to talk about here today? In other words, pancreatitis, the development of necrotizing pancreatitis? How it presents on imaging, those types of things?
A. Well, there's a nice chapter on pancreatitis in there.
Q. Okay. And we'll look at it in a minute but is that something you authored or somebody else?
A. No, that was authored by another person.
Q. Okay. Is there a reason that you brought it here today?

A. I just thought -- maybe you'd want to buy it. That's one of the reasons.
Q. Okay. Well, I may. With respect to any other textbook, is there any other textbook or literature that you're going to be relying upon?
A. No.
Q. Are you relying upon anything in the textbook we just identified?
A. Not really, no.
Q. Is there any other document that we haven't discussed that you're going to rely upon or that you're going to reference in this case in terms of your testimony?
A. No, nothing that comes to mind.
Q. Your practice -- do you practice interventional radiology?
A. A very low end interventional radiology. A very, very small part of the practice, which is biopsies and abscess drainages. But some of the high end interventional stuff, no.
Q. Is there a separate board for interventional radiology?
A. There's actually a certificate of avid qualifications in interventional radiology, which I

do not have.
Q. Do you perform ERCP?
A. No.
Q. When would be the last time -- have you ever performed an ERCP?
A. No. However, from 1978 to 2002 I fluoroscoped for thousands of ERCP. In 2002, we got a new GI lab and so they have their own fluoroscope, and they do their own imaging now. But for more than 20 years, I was involved in the ERCPs, not performing them by any means but by taking the X-rays during.
Q. And you would be involved with the fluoroscopy during the procedure over the time period that you've talked about; is that right?
A. That's right.
Q. How often would you do that?
A. Three or four times a weeks.
Q. And so you've done thousands it sounds like where you've played a role in ERCP in the operating room; is that right?
A. Actually, it's done in fluoroscopy down in radiology, right.
Q. Okay. So I'll rephrase the question.

You've played a role in thousands of ERCP as involved with the fluoroscopy in the radiology suite over the years that you've talked about; is that right?
A. That's correct, not passing any catheters or anything like that.
Q. And I guess that was my next question. Any other role that you play during the ERCP in the time period that you've talked about?
A. No. Other than that, you know, the most common question is where are we or where I am.
Q. Sure. The fluoroscopy during an ERCP, is it kind of like a movie or a film of what's transpiring during the procedure?
A. It's kind of like a video but we don't do videotapes of what's going on during that. We just take static images.
Q. Right. And in this case, all you had to go on was static procedures for this procedure that we're going to talk about today; is that right?
A. That's right.
Q. Okay. Do you play a role as a consultant in terms of ERCP, how the ERCP is to be performed?
A. Oh, no. You know, I interpret the ERCPs

after they've been performed. And sometimes if they have a question from the GI lab, they'll call me up, could you come down and look at this. But that's very seldom.

Q. Okay. On those occasions, what would be a reason that they would need your interpretation of an image to answer a question? What type of question?

A. The question is, this is very weird ductal anatomy or what do you think about this. But again, this is probably once a year.

Q. Am I correct that in this case you're not going to render any opinions about the standard of care for my client; is that right?

A. That's correct.

Q. Am I also correct that you're not going to render any opinions regarding his operative technique in terms of whether it's appropriate or inappropriate; is that right?

A. That's correct.

Q. Okay. Your role in this case is to discuss the images that you reviewed; correct?

A. Right.

Q. And also to draw some conclusions about

what you saw; is that right?

A. Correct.

Q. The -- we have a disclosure here. Have you seen this --

A. Yes, I have.

Q. -- document?

A. Yes, I have.

Q. Do you have it in front of you? So it's six pages long and then it has your CV attached.

A. Yes, I have it.

Q. And this is a document that was obviously shared with you before today; is that right?

A. Yes.

Q. If you look at paragraphs one, and these are small Roman numeral i through small Roman numeral -- well, I guess it's really just small Roman numeral i and ii. Take a look at those.

And I just want to ask you, are those -- does that contain the entirety of your opinions in this case?

A. Yes, it does, unless I'm presented with new information or any new depositions that I'm presented with.

Q. I appreciate what you're saying. But as

you sit here today, Mr. Ginzkey has prepared a document that contains your thoughts and conclusions in this case; is that right?

A. That's correct.

Q. Okay. Are you going to render any opinions about the incidence of ERCP? In other words, how -- I'm sorry, the incidence of pancreatitis related to ERCP? Do you have any opinions you're going to render about that?

A. No, I would defer to a gastroenterologist.

Q. Okay. Are you going to render any opinions about the scoring of this patient either for the indications for ERCP or for the development of pancreatitis? In other words, the risk of developing pancreatitis?

A. No.

Q. That would be outside the area of your expertise?

A. By scoring, you know, there's scoring in terms of severity of the pancreatitis on imaging.

Q. Right.

A. But in terms of scoring for indications for ERCP, no.

Q. Are you familiar let's say with the APACHE

III score and those type of things?

A. Yes, I am.

Q. And are you going to render any opinions about her scoring as it relates to that?

A. No.

Q. There's a rank in score also, you're familiar with that?

A. Yes.

Q. Do you use those scoring systems at all in your care and treatment?

A. No, I don't use them -- in my dictations.

Q. Have you ever provided care and treatment to a patient with pancreatitis in a clinical setting?

A. In terms -- diagnostically, yes. In terms of abscess drainage or fluid collection drainage, yes.

Q. How about in any other fashion? In other words, follow the patient clinically, are you involved in that?

A. Oh, no, not at all.

Q. That would be left to gastroenterology?

A. Or the interventional radiology, you know, which now has its own service and they go on rounds

every morning to see patients they've done procedures with or have catheters.

Q. Okay. Are you going to render any opinions about the surgeries, the surgery this patient had? She had a surgery of May, May 10th and she had one later in August?

A. That was at Barnes, right?

Q. Both at Barnes, yeah.

A. No.

Q. Do you have any opinions about the appropriateness of the ERCP at Barnes? In other words, whether it was indicated or not? So she leaves my client's care. She goes to Barnes. They do an ERCP. You remember that; right?

A. That's right.

Q. And do you have any opinions about the appropriateness of doing that or inappropriateness of doing that?

A. No, I don't.

Q. Okay. Well, that's going to keep this a lot shorter. I guess just to cover this, the revised Atlanta classification, is that something you're familiar with?

A. Yes, and it's in the new book.

Q. And is that something you're going to testify to in this case? You hadn't thought that you were going to I take it?

A. No, I was just going to show the fluid collections but not -- I wasn't planning on it. Specifically just showing where the fluid collections are.

Q. Did you come to some conclusion that this patient developed SIRS at some point in time?

A. Again, I would leave that to a clinician but --

Q. So you don't have any opinions one way or the about whether she developed SIRS?

A. I do but I'm not going to offer it at trial. And I would defer to the managing physician.

Q. Got it. Okay. Do you have a familiarity with the concept of a dysfunction of the sphincter of Oddi?

A. Yes.

Q. And are you going to testify one way or the other whether this patient had that?

A. No.

Q. Okay. I'm sorry, but this will shorten the deposition kind of going through what you're not testifying about.

Let's do this. If we look at the opinion disclosure -- I'm not going to mark this as an exhibit because I think we all know what it is. But for the record, it's Plaintiff's Supreme Court Rule 213 (f)(3) witness disclosure of Richard M. Gore, M.D., filed on July 5th, 2017. If we look at the small Roman numeral ii, a., it says Candice Cain's 3/1/12 ultrasound showed no stone in her common bile duct.

Do you want to pull that up and show me what you're going to show the jury about that?

A. Sure.

Q. Can you just identify what we're looking at?

A. We're looking at slide number 15 now. And actually let me brighten the image.

Q. And just for the record, the 15 that you're showing me is different from the 15 I have on disk that I was given?

A. That's correct.

Q. Okay. So you better identify this then?

A. So this is slide number 15. This is a

longitudinal sonogram of the right upper quadrant. And towards the left of the image is the top and towards the right is the bottom. In front or the top of the image is the skin surface. And this structure that I'm highlighting now is the liver. And here we can see the portal vein. And on top of the portal vein we see a nice, slender, beautiful normal common bile duct.

Q. Okay.

A. And we don't see any distal -- we don't see any -- the common bile distally because of gas but there's no biliary dilatation or stones within the bile duct here.

Q. Can you tell if there's any sludge?

A. I don't know see any sludge either.

Q. If the report from the radiologist indicates that there is some sludge in the common bile duct, would you disagree with that?

A. Okay. Not that I saw. But if they -- and perhaps they saw it in real time. I did not. I was not there real time.

Q. You wouldn't disagree with the report if that's what it says?

A. If the report said that, I wouldn't

disagree if that's what they found.
Q. So had you --
A. Just on the hard copy images I see, I don't see it. However, you know, they were there at the time and they would have presumably visualized it.
Q. When you say they, you mean the radiologist who looked at this ultrasound at the time may have seen it and because they were there real time; is that right?
A. Correct.
Q. What I'm looking at, just for the record, is image 27 on the disk that we have and that looks like the same one that you now noted as 15; is that right?
A. That's correct.
Q. Okay. And so the -- have we covered whatever you're going to talk about with respect to Roman numeral ii, a, on the disclosure?
A. That's right.
Q. Let's go to ii, b, which is Candice Cain's intraoperative cholangiogram.
A. All right. And you have that as well but I think it's in a different order here. The

And here is the common bile duct. Here is the common hepatic duct. The right intrahepatic duct and the left intrahepatic duct and here is the cystic duct remnant and that shows no bile duct stones.
Q. Can we stop for a minute?
A. Sure.
Q. The image that you note -- that's noted as number 24 on the disk and the images that we're looking at is actually 15 on my version; is that right?
A. That's right.
Q. Thank you. So any other thoughts or opinions that you're going to render regarding this image or the images about the intraoperative cholangiogram that we haven't covered?
A. Okay. Also there's free flow of contrast material into the duodenum and that applies. There's no blockage or obstruction.
Q. Okay.
A. And 25.
Q. Which would be the next?
A. Yes. Is just another picture from that. It doesn't show anything terribly different.

intraoperative cholangiogram I'm going to be showing you are on my slides 22 through 34. And you -- yeah, you will have the identical slides.
Q. So I have 14, 15, 16, 17 through 25?
A. Right.
Q. Thank you. So tell me what you're going to show the jury with respect to this intraoperative cholangiogram?
A. This is an intraoperative cholangiogram that was performed on 3/7/2012 by the surgeon. And this is an image from that study. We're going to be showing a number of images. To our left is the patient's right. And to the patient's right -- to our right is the patient's left. This is head and foot. And here is the laparoscopic trocar that the surgeon puts in to do the surgery.
There are usually four or five that are put in. And there's a catheter in the common bile duct. And the common bile duct is here, but it's partially obscured by contrast in the duodenum. We see it better on slide number 24.
Slide number 24, here we're going a little bit north. We can see the diaphragm here. Here is the spine. Here is some ribs. Here is the heart.

Q. That would be 16 on the version I have. Go ahead.
A. Right. And then 26.
Q. Which would be 17 on the version I have.
A. And about the same.
Q. Okay.
A. 27, the same. And 28 I have some arrows. The white arrow shows the intrahepatic bile ducts. And the yellow arrow points to the common hepatic duct -- no, actually at this point it's the common bile duct. And I don't see any filling defects within it.
Q. And this is -- on my disk it's image number 19?
A. Right.
Q. Okay. And did you put the arrows in or --
A. I put the arrows.
Q. Next?
A. Okay. On slide number 29, which is your slide number 20.
Q. 20. Right.
A. We see the surgical clips from the cholecystectomy. These two black lines. Then we see the cystic duct remnant, and these are the

valves of heister, H-E-I-S-T-E-R, of the distal cystic duct. Here we can see the common bile duct. The common hepatic duct here. And there are no filling defects within the biliary system.

Q. Okay. And that's my number 20.

A. Okay. Number 30, pretty much the same. And that's your slide number --

Q. 21.

A. -- 21. Slide number 22, again, no real filling defects within the cystic duct remnants, the common hepatic duct or the common bile duct. And contrast materials goes nice and freely into the duodenum so there's no blockage.

Q. And that's your number 31?

A. 31 and your number 22.

Q. Yes, sir.

A. And slide number 32 is your slide number 23. My slide 32 is your slide 23. And here we can see the cystic duct remnant in red. And here we can see the catheter that the surgeon puts in to inject the dye. Here is the common hepatic duct in white arrow and the common bile duct the yellow arrow. And again, there are no filling defects within that structure. And ditto on slide number

-- on my slide 33 is your slide --

Q. 24.

A. -- 24.

Q. So it shows the same thing, is that what you're saying?

A. That's correct. And again, free spillage of contrast material into the duodenum. Here is the spine. And the same thing on my slide 34, which is your slide 25. Okay. And then I have on slide number 35, I have a demonstrative of what we're looking for when you do an intraoperative cholangiogram. One of the things you look for is a retained common bile duct stone. And so on my slide 35 -- I think you have that somewhere.

Q. I don't remember seeing it. I'm not saying it's not on there.

A. Okay. So on slide number 35, we have Candice's cholangiogram, intraoperative cholangiogram on the right. And we have a different patient who has common bile duct stones on the left. And in the patient on the left is a different patient we can see where my yellow arrows are, these are two retained common bile duct stones.

And those are the type of the filling defects. The contrast is dark, it's black and gray. And what you're looking for is a white filling defect, which is a stone. Okay. And I don't see those. And there -- none of these are present on the cholangiogram of Candice.

Q. The intraoperative cholangiogram?

A. The intraoperative cholangiogram, correct.

Q. Okay.

A. Okay. So these are the points or the illustrations that I'm going to be showing on the intraoperative cholangiogram.

Q. So we've covered what you're going to describe to the jury with respect to the intraoperative cholangiogram?

A. That's correct.

Q. Okay. Next is number -- letter C. This is kind of a fact question. Neither Dr. DeWeert nor his staff obtained additional imaging prior to his 4/4/12 ERCP. That's just a fact; is that right?

A. That's correct. And then I might show the jury what an MR scanner looks like.

Q. Okay.

A. And that's on my new slide 36 and slide number 37. And this shows an MRCP in a different patient, slide 37. And it's probably the best -- not probably. It is the best non-invasive way of detecting biliary stones.

And in this patient, again, this is not Ms. Cain, we can see the stone in the distal common bile duct, and it's causing a blockage and upstream biliary dilatation of both the common bile duct, the common hepatic duct and intrahepatic bile ducts.

And this little structure coming out here is the pancreatic duct. And again, this is a very elegant technique. And the nice thing about it is there's no radiation involved. And so you just sit in a big magnet and you have radiofrequency pulses sent through you.

Q. Okay.

A. Okay. And so this is now, you know, the best way to non-invasively look if there are common bile duct stones.

Q. Are there variations with respect to imaging obtainable on MRCP depending on the equipment?

A. Let's see. I think after 2010, I think it's been pretty standard you can get -- you can get an excellent image I think from all vendors to be competitive.

Q. Do you have any information about the MRCP equipment available to Dr. DeWeert back in 2012?

A. Let's see. At least on slide -- my new slide 48 at Bromenn Regional Medical Center, boy, they had kind of the Cadillac. They had a 1.5 Tesla Phillip scanner, so that's a great scanner.

Q. So the equipment at least at Bromenn was the type that could -- that would provide you the images that you were after? In other words, there wasn't degradation of the images based upon the equipment, is that what you're saying?

A. That's correct.

Q. Okay. So the next part of C is more likely than not Candice Cain had no stone in her common bile duct on 4/4/12 and that's based on the images that you reviewed; is that right?

A. It's based on the intraoperative cholangiogram and also the preoperative ultrasound study.

Q. Is there anything else that you're basing

that opinion on?

A. Also on the MRCP study that was done after the ERCP of 4/4/12, I didn't see any common bile duct stones here.

Q. Were there stones mentioned in any report with respect to the postoperative MRCP?

A. Let's see.

MR. GINZKEY: I'm sorry, can you repeat that question?

(Whereupon, the record was read as requested.)

THE WITNESS: Okay. On the postoperative MRCP, the paragraph before the impression says common duct is dilated measuring approximately 1 cm in caliber. Small area of hypodensity in the inferior aspect of the common bile duct measuring 0.5 by 0.3 cm seen on coronal T2 series 501, image 22.

This may be her stone or another piece of debris. This abnormality is touching the wall of the common bile. It's not actually physically obstructed the duct.

BY MR. BRANDT:

Q. Any disagreement with that report?

A. I saw it on that image. But when you're

reading an MRCP, you've got to see it on multiple different images. I just -- I see what they're talking about but I guess I disagree with that.

Q. You do disagree with that?

A. Yeah. I think it might be sludge or something else, but it doesn't look like, you know, it's a stone down there.

Q. Would it be a fair statement to say there's -- it's inconclusive?

A. Yes.

Q. Okay. Anything else that you're basing this opinion on with respect to the proposition that more likely than not Candice Cain had no stone in her common bile duct on 4/4/12?

A. Okay. Well, we actually had the real gold standard, which is, you know, the best -- probably the best invasive -- is the intraoperative cholangiogram, and I didn't see any stone on that one. And so what was seen on the MRCP may have been an artifact or some debris.

Q. Or it may have been a stone?

A. No, I would disagree with that. More likely than not it was not a stone.

Q. But certainly there is a disagreement --

or not a disagreement but it's unclear based upon the report exactly what's going on at the time that the MRCP is being performed?

A. That's correct.

Q. Okay. Is there anything else -- and just to cover the foundation for your opinion, is there anything else that you're going to base this opinion on that more likely than not Candice Cain had no stone in her common bile duct on 4/4/12 other than what we've just talked about?

A. Okay. The pre-operative ultrasound, the intraoperative cholangiogram and the immediate post-operative MR. No, that's what I'm basing it on.

Q. The MRCP?

A. The MRCP.

Q. Let's go to D.

A. Okay.

Q. Image obtained by Dr. DeWeert 4/4 ERCP shows that a guidewire perforated Candice Cain's pancreas. Okay. So let me just ask you a couple prefatory questions, if you will.

These are snapshots taken during the time period the ERCP is being performed; is that right?

A. That is right.
Q. And the snapshots that you're looking at are timed; is that right? You're given an image time; is that right?
A. That's correct.
Q. In total, how many snapshots did you look at or were you provided either one?
A. One, two, three -- one, two, three, four, I think -- I don't recall. These are the four that I selected. There might have been more on the disk, but I don't recall specifically.
Q. There's four that you're going to present to the jury as representative of what was going on during the ERCP; correct?
A. Right.
Q. Okay. So let's look at those, and if you can just read off the numbers to me and --
A. And you should have it on the old version as well. Much lower number.
Q. Right.
A. Yeah, with the new PowerPoint I put things in chronological order. I don't know why.
Q. So I think my memory is that it's --
A. There you go.

Q. Okay. So I'm looking at image number 49 and it looks like it's your 39; is that correct?
A. That's correct.
Q. Go ahead.
A. Okay. Here we have an image from the ERCP. This was taken at 11:03 in the morning of 4/4/12, and we see a little contrast material. I believe it's in the pancreatic duct.
Q. Can you tell with any certainty?
A. It doesn't look like the common bile duct but -- either that or it's a false tract, you know, that sometimes develops during a performance of an ERCP, so I can't tell with certainty.
Q. Thank you. Go ahead. The next image is?
A. The next image is my image 40, your image 50.
Q. Thank you.
A. And this image was taken at 11:44 in the morning of April 4th, 2012. And here we can see the ERCP scope. And here is the scope in the stomach and the stomach is going into the duodenum and going into the descending duodenum. And here is the side viewing port of the endoscope. And here is the guidewire that unfortunately has, you know, penetrated through the pancreas. Here we can see the surgical clips from the cholecystectomy.
Q. Can I ask you a question?
A. Yes.
Q. With respect to the bottom arrow, is that where, in your opinion, the pancreas ends? In other words, where the perforation took place?
A. Probably.
Q. And you're basing that on contrast or are you -- is there a contrast that you're looking at to draw that conclusion?
A. No. Just that the guidewire is where it should not be.
Q. In its entirety, is that what you're saying?
A. Okay. The guidewire from this point to the end is not where it should be.
Q. Okay. So am I correct then that based on the image that we're looking at your 40, my 50, number 50, the -- from an anatomical standpoint, the pancreas ends somewhere around where the lower -- the bottom arrow has been placed, is that a fair statement?
A. Yes, approximately.

Q. Okay. And can you tell from this image how long the guidewire, you know, distance wise it exceeds the envelope of the pancreas?
A. Okay. No, we don't have a marker on here. But let's say -- let's see. I'm looking at the side of vertebral bodies. And how tall was Candice, do you recall?
MR. BRANDT: She was 5' 2", does that sound right, Jim?
MR. GINZKEY: I was going to say 5' 4" but I don't recall.
MR. BRANDT: I don't know the answer.
THE WITNESS: So looking at the vertebral body, maybe this is -- maybe 12 or 15 centimeters beyond the pancreas.
BY MR. BRANDT:
Q. And have you seen this before in your practice? Have you seen a guidewire go beyond the perimeter, if you will, of the pancreas?
A. Actually not, no.
Q. Have you in your articles that you've written or in the textbook chapters that you've been involved in either as an author or as a co-author described the phenomenon?

A. No. Perforation is, you know, a complication but it's -- the perforations that I've seen are actually of the lumen. You know, you perforate the duodenum or you perforate in the region of the sphincter of Oddi. But I haven't seen this perforation.

Q. Have you seen or written about other -- written generally about perforation of the pancreas as a complication?

A. A perforation is a complication of ERCP, but the perforation we're describing is the one around the papilla and of the duodenum, not of the pancreas itself. I haven't written about that.

Q. Okay. And is the type of perforation that you're describing here on your number 40, my 50, is that type of placement of the guidewire in this location something that's been described in the literature?

A. Not that I've seen but, you know, it might be but not that I've reviewed.

Q. Is the location of the guidewire in this case nonetheless a risk of the procedure itself?

A. Is pancreatic perforation a risk of ERCP?

Q. Yes.

A. I think that would be best left for a gastroenterologist.

Q. Okay. Very good?

A. But it's just that I haven't seen it nor have I read about it.

Q. Very good. So does that cover number 40 in terms of what you're going to talk about with the jury?

A. Right. And I have some -- okay.

Q. So you can go to the next one if you'd like.

A. Okay. And so I added this little diagram here showing that. So this is a demonstrative showing the ERCP scope going through the stomach into the duodenum.

Q. Yes.

A. And then this is kind of the trajectory of the guidewire rather than into the common bile duct. It's kind of extending beyond the pancreas. And similarly on 41, which is your --

Q. 51.

A. -- 51, again, we see pretty much what we saw in 41. And here I think there's a little bit of -- on this one we can see a little bit of

contrast material within the pancreatic duct, and then we can see is the guidewire unfortunately penetrating and perforating the pancreas. And so, again, it's got that kind of trajectory, which I'll show the jury.

Q. Okay.

A. And 42 is just the scout image and it's your 52.

Q. Right.

A. And then on 43, this is a side by side comparison. An ERCP was done on 4/4/12 and then on 4/6/12. And so the real trajectory of Candice's common bile duct is this way. Because here we can see the surgical clips from the cholecystectomy and here we can see the surgical clips from the cholecystectomy.

And so you can see that on the ERCP of 4/4/12, the guidewire is this far away from the clips on the cystic duct but -- and the reason for that it's not in the common bile duct. It's -- you know, it has penetrated and perforated the pancreas. And here the ERCP that was done at Barnes, we can see the -- where the real common bile duct is. And you can see the separation

between the duct and the clips is this far. So theoretical -- you know, not theoretically, this guidewire should have been in this position.

Q. If the guidewire had gone where the gastroenterologist had wanted it to go, it would have gone in that direction; true?

A. It would have gone in this direction.

Q. In a direction that you think is representative on the 4/6/12 ERCP, which is on the right side of the page; is that right?

A. That's right.

Q. And that's my number 53, your number 44?

A. 44.

Q. Was there anything -- while we're on the page, is there anything about the ERCP done on 4/6/12 that indicates any problem with the guidewire? Let's just start there.

A. Let's see. The guidewire looks like it's coiling within the intrahepatic duct so that looks okay.

Q. Okay. Is there any indication that the guidewire on 4/6/12 entered or was -- perforated the -- if you can just go back to it.

A. No, actually why don't we go to the 4/6/12

ERCP.

Q. Okay. Well, let me just finish my question.

A. Okay.

Q. Is there anything that indicates that the ERCP done on 4/6/12 that shows you that the guidewire entered the pancreas or perforated the pancreas, either one?

A. Can we go to those images?

Q. Yes, we can.

A. And so this is the ERCP on 4/6/12. This is my image 50. And let's see. And I think it's my image 51 and it's your image 55.

Q. I think that's right.

A. Okay. So this is the scout image of the ERCP done on 4/6/12. And we here we see some surgical clips from the cholecystectomy at this point. And here is the spine. Here is the scope in the stomach. And here is the scope in the descending duodenum.

And here we can see on slide number -- my 52, is your slide 56. And we can see the guidewire in the common bile duct. And on slide 53, which is your 54, the gastroenterologist put a balloon in

the common bile duct. And that's what this white area is.

And on slide number -- so that was my slide 53 is your slide 58. And my slide 54 is your slide 59. And so here we can see the balloon just about to come out the papilla of Vater and the sphincter of Oddi.

And so my 56 is your 60. And we can see again this distal -- the balloon in the distal common bile duct. And on the next image of my 56, which is your 61, the balloon is no longer there. The guidewire is still there.

Q. Right.

A. And then on slide number 57, at the end of the examination the gastroenterologist put in a plastic biliary stent, which is depicted by the red arrow.

Q. And that's my 62. So do you have an understanding of why the biliary stent was placed?

A. Nothing that comes to mind. I think it's probably best to ask the gastroenterologist.

Q. Okay. So back to my question. My question was is there any indication on the ERCP of 4/6/12 that the guidewire entered the pancreas or

perforated the pancreas?

A. No.

Q. Do you have any opinions about whether the ERCP just performing it on 4/6/12 was -- exacerbated the patient's pancreatitis or is that a gastroenterology question?

A. I would refer to a gastroenterologist.

Q. So have we covered the images that you are going to discuss with respect to opinion D on the disclosure?

A. Correct.

Q. Okay. So let's go on to E. E says, I'll just put this in the record. An MRCP obtained shortly after Dr. DeWeert's 4/4/12 ERCP shows severe peripancreatic and retroperitoneal edema consistent with acute pancreatitis, and a small piece of debris or small stone that was not obstructing the common bile duct.

Did I read that correctly?

A. That's correct.

Q. Let's look at the images.

A. Now, these images I think I'm going to have to reshoot because they're really dark. We'll probably be giving you a new PowerPoint prior to

trial.

Q. Thank you.

A. But on slide number 40 -- you don't have these.

Q. I don't have these?

A. You don't have these. So on slide number 46 --

Q. Can you just identify this is the date?

A. This is the ERCP that was performed on 4/4/12. This was done at Bromenn Regional Medical Center.

Q. This is the MRCP?

A. This is the MRCP. And this was done at 9:26 p.m., the date of the ERCP.

Q. Yes. April 4th, 2012?

A. April 4th, 2012. And an MRCP at least on this sequence fluid is white. So here we can see white fluid and the cerebral spinal fluid. And then we see fluid surrounding the pancreas. Fluid surrounding the kidney. Again, more fluid in the retroperitoneum.

Q. Now, we're looking at your 47?

A. 47. And then we're seeing fluid in the retroperitoneum on the patient's left and the

patient's right. And again, on slide number 46 more retroperitoneal fluid. I'm sorry these came out so dark.

Q. 48.

A. And 49, this is the coronal reformatted image.

Q. It's upside?

A. No, actually the data is upside down. So here we can see the --

Q. This is the coronal view?

A. The coronal view. But I think -- I'm going to have to re-do these and so you can see them a little bit better.

Q. The point of these is that it shows the fluid that you described in the disclosure. And the disclosure talks about peripancreatic and retroperitoneal edema?

A. Yes.

Q. Where are you seeing that?

A. The edema I guess -- edema is fluid.

Q. Okay. So for purposes of your opinion when you talk about edema, the manifestation of that is the fluid collections that you're seeing has white on these images?

Q. No, I'm talking about in terms of drawing a determination of severity?

A. This looks moderate to severe.

Q. Okay. And so what's the basis of that? I mean, how do you draw the distinction between mild, moderate and severe?

A. I think it's like in the eye of the beholder, you know.

Q. So it's just based upon your education, training and knowledge of looking at MRCP for patients who have pancreatitis?

A. That's right.

Q. And from that, you've drawn the conclusions she has moderate to severe; is that right?

A. Correct.

Q. Do patients who have -- let me ask a better question.

Are there other indices of pancreatitis other than what you've just shown the white areas, the fluid areas?

A. Okay. Yeah.

Q. On the images I mean?

A. On these images, no, that's why I can give

A. That's right.

Q. And when you say it's consistent with pancreatitis, is it consistent with anything else in your opinion? I mean, can it be consistent with just having an ERCP?

A. No, it's not consistent with just having an ERCP.

Q. Why do you say that?

A. Because you do not get these findings on an ERCP.

Q. Can it be consistent with just having had -- or having recently had a lap choly?

A. No, because these fluid collections are retroperitoneal and a lap choly is a completely intraperitoneal success so, no.

Q. And so have you seen images of this type in other cases? I assume you have?

A. Oh, in patients with pancreatitis?

Q. Yes.

A. Yes, all the time.

Q. And so is -- can you -- from the images that we've looked at, measure the amount of edema or fluid collections?

A. You mean in terms of number of cc's?

you more. But if you look at the pancreatic gland itself, you look at the degree of enhancement, you look at the amount of fluid, where the fluid is located, you look for dilatation of the pancreatic duct, you look for involvement of other organs.

Q. When you looked at the images that we've just looked at from the MRCP done on the day of the ERCP, did you find any of those indices?

A. Indices, the pancreas looked edematous. Also, you know, these fluid collections were going into the retroperitoneum and down the transverse mesocolon. So they were abutting the stomach and the kidneys and the transverse colon.

Q. And so can you have all those findings in mild, moderate and severe?

A. Not in mild, no.

Q. You can have it in moderate?

A. Probably not moderate. Moderate to severe or severe.

Q. Okay. I'm having trouble drawing this distinction between what you've just said. You said moderate to severe --

A. Okay. You cannot see it -- okay. Let's say there's mild, mild to moderate, moderate to

severe and then severe. So you see it moderate to severe and severe.

Q. I see what you're saying. Any other indices that you would see on this MRCP that we haven't talked about -- I'm sorry, let me re-ask a better question.

Is there anything on the MRCP that you saw that supports your opinion?

A. No, that's it. But again, I've got to re-do these slides, and I will give them to you well before trial.

Q. But I understand that you've just rendered an opinion based upon having looked at them in a different light so to speak and drawn a conclusion that there was edema in the pancreatic duct; right?

A. No, there was edema in the pancreas. There are peripancreatic fluid collections. These fluid collections went retroperitoneally to the right and the left. They went down the transverse mesocolon. They were abutting the kidneys. They were abutting the transverse colon and on the stomach.

Q. I guess from your memory of looking at these in a different light, did you find things

that are not demonstrative on what we just looked at, that manifested in what we just looked at?

A. Yeah, and that's why I probably need to make some more images.

Q. So when you testify at the trial of this cause, you're going to testify that there are other structure -- there are other indications of mild to moderate -- I'm sorry, moderate to severe pancreatitis that we just can't see today?

A. That's correct.

Q. And you've told me about all of those; is that right?

A. Correct.

Q. Okay. There's a small piece of debris -- I'm sorry, I'm back reading the report or the opinion disclosure sub E and it says this, with a small piece of debris or small stone that was not obstructing the common bile duct.

Can you show me where that is on these images?

A. No, I don't have it on the image but -- the images I prepared for today.

Q. Is this accurate?

A. Oh, no. Acute pancreatitis in a small

piece of debris or small -- no. No, there is no small stone or piece of debris in there. I thought that's what I was trying to imply. And a small piece of debris or small stone that was not obstructing the common bile duct.

Q. That's what I'm asking. Is that an accurate statement?

A. I do not see a small piece of debris or a small stone obstructing the common bile duct. Maybe the sentence could have been created better.

Q. It's okay. Is there, in fact, a small piece of debris or small stone anywhere on the MRCP?

A. Not that I saw in the duct, no.

Q. Did you look at the report from the MRCP?

A. Yes, I did.

Q. Okay. Take a look at that and tell me if you have a disagreement with what was reported there or if their findings are inconsistent with yours?

A. Okay. As I said -- you know, they said this may be a stone or other piece of debris. And remember I said it. I saw what they were talking about on that image but I didn't see it

inconsistently so that's why I don't believe there is a stone or piece of debris there.

Q. So you'd have a disagreement with whoever read this MRCP at Bromenn; is that correct?

A. That's correct.

Q. Okay. The next -- going back to the disclosure, Dr. Gore. F says, Dr. DeWeert's 4/4/12 ERCP caused Candice Cain's acute pancreatitis.

I take it from what you've told me earlier that that's really something you're going to defer to gastroenterology about?

A. Well, I see a guidewire perforating the pancreas and so --

Q. That's the basis of your opinion?

A. That's correct.

Q. And --

A. I don't have another cause.

Q. Okay. And do you have other basis for your opinion other than what we looked at in terms of images?

A. Other than --

Q. For instance, such as clinical manifestations, that type of thing?

A. Well, the amylase and lipase levels, you

know, increased during that day significantly. And so just putting one and one together.

Q. Okay. Anything else that you're going to base an opinion on that she developed acute pancreatitis as a result of the ERCP?

A. Other than, you know, the guidewire penetrating and perforating the pancreas and that tremendous bump in the amylase and lipase afterwards, no, that's it.

Q. If we look at G. Okay. It says this, 4/6/12 ERCP in St. Louis showed mild extra hepatic biliary duct or dilatation -- or dilation without evidence of filling defect. Again, demonstrating the absence of stone in Candice Cain's common bile duct.

Have we covered that already?

A. Yes.

Q. And we've covered that by looking also at the images from that ERCP; true?

A. Right.

Q. Okay. The last one H says, imaging from St. Louis between April and August of 2012 shows the Candice Cain's pancreatitis worsened to necrotizing pancreatitis and autolysis causing

severe organ damage resulting in prolonged hospitalization and death.

Okay. There's a lot there. First off, just tell me generally, you -- there are a lot of images. There's over 200 pages to this PowerPoint. Obviously you're looking at a number of things that are going on not the least of which are chest X-rays and alike.

Okay. My first question is, is overall what's the basis for your opinion that -- I mean, what is it base wise in terms of your opinion that these things happen? I assume from what you're going to tell me is based on the images alone; right?

A. The imaging studies, correct.

Q. Because you really haven't looked at the medical records -- clinical records from Barnes; right?

A. I have. But again, that was over a year ago.

Q. Would it be a correct statement that your opinions then are based solely on the images as you sit here today?

A. The images and also looking at the autopsy

report and apparently they carefully or they did look at the Barnes medical records as well.

Q. They being the pathologist?

A. The pathologist, right.

Q. And this was Ms. Scantlebury?

A. Yes.

MR. GINZKEY: Dr. Scantlebury.

BY MR. BRANDT:

Q. So what do you see in this case? What's going on with Ms. Cain that you can summarize for me?

A. Some are -- you know, I've got to --

Q. We'll go through them. And I'm not going to go through every one.

A. Okay. And, you know, I wouldn't do that at trial because I'd put everybody to be sleep, I think.

Q. I think so, too. But I just want to know how you come to this conclusion. And I assume you've looked at these images before we came in here today; is that right?

A. Yes. I'm the one who downloaded them.

Q. But, I mean, you've probably looked at them recently; is that right?

A. That's correct.

Q. Okay. So what's going on with Candice Cain over this time period from April to August?

A. Okay. During this time period, the necrotizing pancreatitis is just being unrelenting and progressive and leading to fluid collections and fistulae and abscesses, and it's just kind of a downward spiral that continued, you know, over this course of months.

Q. And so have you seen this in other patients?

A. In pancreatitis, yes.

Q. And have you seen patients -- have you seen images of patients who have necrotizing pancreatitis?

A. Yes.

Q. And so at least what you're seeing here is consistent with that? In other words, the images that you see of Candice Cain over this April to August of 2012 period are consistent with a patient who has developed pancreatitis that then evolves into necrotizing pancreatitis; is that right?

A. That's right.

Q. Can you tell from the images, and we'll

look at them here for a minute, when her pancreatitis became necrotizing pancreatitis or do you have in your mind the memory of the case as to when that occurred?

A. Certainly by April 12th. And again, I'm going to have to review again the immediate MRCP -- post-MRCP images but certainly by April 12th.

Q. And what's the basis for that opinion?

A. You know, the abnormal enhancement of the pancreas, the abnormal fluid collections.

Q. All right. And is it necrotizing at that point, in your opinion, or can you tell?

A. Certainly by the 11th, yes. By radiologic criteria.

Q. And what is the criteria looked at to make a determination that it's something other than just pancreatitis?

A. Okay. In necrotizing pancreatitis -- and actually I might show somewhat, you know, what mild pancreatitis looks like as opposed to necrotizing pancreatitis. In mild pancreatitis, sometimes the glands gets a little bit swollen. However, on MR and CT when you have necrotizing pancreatitis, part of your gland, you know, when you inject that dye,

it doesn't light up and it gets kind of dead or dying. And so it's darker than the rest of the pancreas.

Q. Okay.

A. And so -- that's primarily at least the imaging diagnosis of necrotizing pancreatitis. Also, that's the earliest sign. And then eventually you may see gas bubbles within it and an abscess.

Q. Anything else that you looked for that would be indicative of the presence of necrosis of tissue?

A. First of all, you see enlargement of the pancreas. Then you see abnormal or no enhancement. And then, you know, with real necrosis, you know, you get gas bubbles within it.

Q. Is there any indication from the images that you looked at that would show you whether or not there's infection?

A. With infection when you see gas bubbles, you're always concerned about infection. But again, that's why you have to stick needles into these things to make sure they're infected or not.

Q. Okay. Do you know at Barnes if they made

a determination when -- in other words, they charted when they determined this patient went from having pancreatitis to necrosis?

A. I don't recall.

Q. Is there anything in the imaging reports that talk about a determination at Barnes that this patient now has necrosis with respect to her pancreas?

A. I have to look at the reports. I don't recall specifically.

Q. And you're not relying upon those reports from what you're saying; is that right?

A. That's correct.

Q. So at the time period that she's at Barnes -- so just to put the timeline together, April 4th she has the ERCP. April 4th, 2012 she has the ERCP at Bromenn. Okay. The next day she's at Barnes on April 5th, is that your understanding?

A. Or very shortly thereafter, yes.

Q. And then she's discharged on April 17th from Barnes, do you have that memory?

A. Right, and then she comes back.

Q. And then she comes back. Okay. And so what you're saying to me is that at the time --

before she was discharged from Barnes, did she have necrosis in her pancreas? It sounds like she did?

A. Yes, she did on imaging.

Q. All right. And are you involved with treatment decisions with respect to necrotizing pancreatitis?

A. No.

Q. And I assume you're not going to render any opinions about their treatment of her, their being Barnes treatment of her from April 5th, 6th through the 17th, you don't have any opinions about that?

A. No.

Q. Did you have any disagreements with -- let me preface it. Did you look at the radiological reports from Barnes? So I'll ask you that.

A. Long ago but --

Q. And do you recall if you had disagreements with the reporting done there and your findings?

A. None that come to mind.

Q. Okay. And the rest -- going back to the disclosure H, it talks about autolysis. Define that for me in terms of your using it?

A. Okay. Autolysis is, you know, you're just

chewing yourself up. You know, lipase and amylase are -- especially lipase, you know, it destroys fat. And amylase, you know, based on protein, and just chew yourself up, you know, the insides of yourself up and so you self-destroy yourself with these enzymes.

Q. These are enzymes that are coming from the pancreas that are affecting adjacent organs, is that a good way to put it?

A. That's right, and also they can get into the systemic circulation, too.

Q. Okay. And you sought images that supported that; is that right?

A. Oh, yes.

Q. And then -- and we're going to go through them here in a second. And then the next phrase is causing severe organ damage, which organs were damaged?

A. Okay. The pancreas, the bowel, the lungs, the liver, the colon, small bowel and there was fistulae of the vagina, I think.

Q. There's fistulization. I don't know if it was vaginal fistulization. I don't remember, I'm sorry. But she did have fistulization. It would

be your opinion that that was caused by the necrotizing pancreatitis, you know, that was demonstrable on imaging; is that right?

A. That's correct.

Q. In terms of cause of death, do you have an opinion about that or are you relying on the pathologist?

A. I'm relying on the pathologist, but, you know, I have seen patients die from necrotizing pancreatitis who have a course like this.

Q. Yeah. Have you had patients who have had a course like this like Candice Cain?

A. Not from ERCP. But with necrotizing pancreatitis, yes.

Q. And how often would you see that type of patient? And I understand it wasn't ERCP related. But how often would you see patients with necrotizing pancreatitis, and by that I mean review imaging?

A. How often do I see patients with necrotizing pancreatitis?

Q. Yes.

A. Oh, probably once a week, once or twice. Necrotizing pancreatitis?

Q. Yes.

A. Yes.

Q. And do you have any information about which ones, what percentage resolve and what percentage expire?

A. No, I don't. Other than they're presented at the M&M conference, no, I don't know the percentage.

Q. Are you involved with anything other than reviewing imaging with respect to those patients? In other words, do you provide any consultation with respect to treatment?

A. Well, they actually -- you know, what is the degree of pancreatitis, is there pancreas necrosis yet, is there a fluid collection, you know, is this fluid collection amenable to drainage and things like that. So, you know, I will consult on that with the surgeon or gastroenterologist or an internist.

Q. Do they ask you about treatment modalities at all?

A. No.

Q. With respect to Candice Cain, do you have an opinion why her pancreas became necrotic? I

mean, why does she -- why does it then evolve into necrosis? Do you have an opinion about that?

A. I don't know. I think you'd have to ask a gastroenterologist or a pancreatologist.

Q. And because some patients who have pancreatitis don't develop necrotizing pancreatitis; true?

A. That's for sure, yeah.

Q. And in the patients that you've been involved with who have necrotizing pancreatitis, do most of them die?

A. No.

Q. Do most of them survive?

A. In my experience, yes.

Q. Would it be 90 percent survive?

A. That I can't give you a figure.

Q. You haven't looked at those numbers?

A. No, I haven't.

Q. Have you written anything about the survival of patients with necrotizing pancreatitis?

A. No, I have not.

Q. Have you written anything about the survival of patients with pancreatitis, period?

A. No.

Q. Okay. The studies that you've been involved in, and I know you've written on this topic and you've -- both in articles and textbooks; is that true?

A. Yes.

Q. What is the focus of the literature that you've written on? What's the focus of your authorships on this?

A. Just what are the manifestations of pancreatitis on imaging but not giving prognosis or treatment.

Q. Did -- let me just cover this while I'm thinking about it. Did this patient have any anomalies with respect to her -- the anatomy of her pancreas or her biliary tract?

A. Not that I saw on imaging, no.

Q. Okay. You've written on that topic; is that right?

A. There are chapters in the textbook, right.

Q. And you've written articles on that topic, too; is that right?

A. Yes.

Q. And to summarize, what are the anomalies that you describe in the literature?

A. Well, actually the anomaly that's most associated with pancreatitis is pancreas divisum, D-I-V-I-S-U-M, in which there is separate drainage of the ventral and also pancreatic duct, and that's the anomaly that's most commonly caused -- associated with pancreatitis. I didn't see any evidence of that.

Q. She didn't have that?

A. No.

Q. Are there other anomalies that are associated with the development of pancreatitis?

A. Yes, you can have patients with annular pancreas. You can get patients who have the common -- the pancreatic duct directly inserts into the common bile duct and that can lead to both cholangitis and pancreatitis. And then patients who it's really not an imaging finding who have sphincter of Oddi dysfunction, and that could lead to elevated pancreatic and biliary enzymes.

Q. Is sphincter of Oddi dysfunction something that you can discern on imaging? I'm sorry if we've covered this.

A. It is said you do an ERCP and you wait 40 minutes. And if the thing still doesn't drain

after 40 minutes, that's sphincter of Oddi dysfunction. But actually you can do manometry of the sphincter of Oddi and it's called tachyoddia, T-A-C-H-Y-O-D-D-I-A, and it can be seen on manometry.

Q. No manometry done for this patient?

A. No.

Q. And so is there any evidence from what you looked at that she has some dysfunction of her sphincter of Oddi?

A. No, because on the intraoperative cholangiogram that stuff shot real -- very nicely from the common bile duct into the duodenum.

Q. Okay. So what I'd like to do is I'd like to walk -- have you walk through the images. And if you come upon an image that simply is cumulative of what you've just said, we can -- you can say this shows essentially the same thing.

A. Okay.

Q. Because as I see it, we've got 204 images.

A. Oh, I'll go very quickly. Can I show you my demonstratives, too?

Q. Absolutely. But let's cover the -- that's fine, too, but let's cover this discrete issue that

we've been talking about here today, which is -- or that we're talking about now which is the worsening of her necrotizing pancreatitis, the autolysis and severe organ damage. Okay?

A. Okay. We're now on new image number 61, and I think --

Q. Go ahead.

A. 61, this was the CT study done at Barnes on April 11th, 2012. And this is a scan of the upper chest -- lower chest, and we can see her heart. And she's got bilateral pleural effusions, and she's got consolidation of atelectasis in both lung bases.

Q. This is my 66.

A. And this is my 61.

Q. Okay.

A. And then we have a scan a little bit further down and she's got ascites in the yellow arrow.

Q. Right.

A. And my slide 62, your slide 61. And she's got bilateral pleural effusions and atelectasis. Again, we're going to be talking about April 11th CT.

Q. And this is my 67. Go ahead. And now this is 63?
A. My 63, your 68.
Q. Okay.
A. So we are at scan in kind of the mid abdomen now. These are the kidneys. Here is the spine, the aorta. Here is the superior mesenteric vein, super mesenteric artery. And here we see the pancreatic head, an uncinate process. And then in the region of the pancreas, the pancreatic head -- I'm sorry, neck, body and tail, just kind of see inflammatory change. And then normally surrounding the pancreas you're going to see fat and bowel but between my two arrows you can see all this inflammatory fluid.
So normally fat is black, but here we see all this gray fluid. And this is fluid in the anterior perirenal space, and there's necrosis of the pancreas at this point. There's also retroperitoneal fluid as well, and there's fluid in the left anterior fascial plane and right anterior fascial plane.
Q. Well, what is it that tells you that on your image 63, my 68 that there's necrosis?

A. Because I don't see enhancement of the pancreas.
Q. Okay.
A. Okay. I see a nice enhancement of the pancreatic head, an uncinate process but not of the tail and the body.
Q. Could the fluid collection be obscuring what you're trying to discern?
A. Well, no, because it's part and parcel of this entire inflammatory process.
Q. Okay. I'm not sure I understand what you said but the answer is no?
A. No.
Q. Go ahead.
A. Okay. We're going further south. My slide 64, yours 69. And here we're seeing some of the inflammatory change in the fat of the greater omentum. And normally fat is black-black on CT but you can see this nasty stuff going into the greater omentum. And then we're seeing some fluid in the lesser sac and also seeing some fluid in the right paracolic gutter and also retroperitoneal and this is fluid surrounding the right kidney.
Q. And this fluid is consistent with

pancreatitis --
A. Yes.
Q. -- is that right?
And is there a reason why some arrows are red and some are yellow?
A. No.
Q. Okay.
A. And we're going further south. My image 65.
Q. And mine is 70.
A. Okay. And then we can see some fluid in the left paracolic gutter, the arrow on our right, the patient's left side. And there's some fluid in the retroperitoneum on the right, which is on our left, the patient's right, going further south.
Q. Your 66, mine 71?
A. Uh-huh. And then we're seeing a lot of intraperitoneal fluid down in the pelvis, and this the peritoneal lining.
Q. Right.
A. This is the sacrum and these are the hips. And this is fluid surrounding the sigmoid colon here. And this is fluid surrounding this structure. And then we can see the peritoneum

here. It's usually like a nice, thin line. This one is a little bit too thick so there's some peritoneal inflammation as well on that image.
Q. And these are all consistent with pancreatitis?
A. Yeah.
Q. Okay.
A. Okay. And then, let's see, we go to the CT study of 4/17/12. You should have this same one.
Q. I think I do. It's just in a different location?
A. There we go.
Q. This is at St. James. Okay. So just from my --
A. I think mine have the wrong date on it.
Q. You did. That's okay.
A. My image 68 is your image 33.
MR. GINZKEY: And what's the date of that image?
THE WITNESS: 4/17/12. I think on the version I gave you it's at 4/7/12, I'm sorry.
BY MR. BRANDT:
Q. And just for the record, this is done at

St. James in Pontiac, Illinois. Okay.
A. Okay.
Q. Is that right?
A. Correct.
Q. If you look at the top there, it says St. James?
A. Uh-huh.
Q. And so let me just ask you generally, are the -- does the MRI that we're going to look at here, are these consistent with fluid collections that you see with pancreatitis?
A. Yes, they are.
Q. Are you going to basically testify to the same things we just talked about relative to the CT scan we just looked at?
A. Yes, but they look worse.
Q. She's got more fluid?
A. More fluid and more inflammatory change.
Q. Let's walk through them then.
MR. GINZKEY: And just a point of clarification, from St. James it's a CT, not an MRI; correct?
THE WITNESS: That's correct.

BY MR. BRANDT:
Q. This is your -- it's my 33, your 68. Go ahead.
A. Right. Okay. We're seeing all this inflammatory change in the greater omentum. We're seeing a lot more intraperitoneal fluid in Morrison's pouch. And then we're going to slide number 96, there's a lot more fluid in the right and left paracolic gutter. And gain, this is my slide 69 and yours 34.
Q. Thank you.
A. And then slide number 70, we're going further south. There's a lot more fluid down in the pelvis. My slide 70, your slide 35.
Q. Yes. Okay.
A. Okay. And then these are some demonstratives. We've been looking at the axial images. I'm going to show the jury this is how we slice a person with the CT like a loaf of bread or an orange.
And now we're going to show the coronal plane. This is like scanning the patient -- slicing the patient like a subway sandwich the long way, and we're looking at that piece of meat in the

center of the subway sandwich.
Q. Okay.
A. And so here is slide number 75, this is a coronal image. And it's your slide number 36. And we can see this is the right, towards the patient's left, head, foot, near the legs. And here we're seeing a lot of fluid in the peritoneal cavity. And here is a lot of inflammatory change seen in the greater omentum.
And this is just another -- okay. And my slide 76 is your 37. And we can see -- we're scanning a little bit further back in the patient. Here is the heart, the stomach, the liver. And this is the plastic biliary stent placed in by the folks at Barnes.
Q. I see it.
A. And then we see these fluid collections that have worsened. And then here we can see on slide number 77.
Q. Mine 38.
A. We can see the stent again.
Q. That's fine. When you describe this, it's better for us in reading the transcript if you just describe what you see rather than saying and here

we have, you know what I'm saying.
A. Okay. All right. On slide number 77, there's a plastic biliary stent. There is a lot of inflammatory fluid identified in the paracolic gutters in the small bowel mesentery and in the pelvis.
Q. And this is a worsening of what you saw at the CT scan at Barnes; is that right?
A. That's correct.
Q. Go ahead.
A. Slide number 78, we're scanning a little bit further back here and --
Q. This is my 39. Go ahead.
A. My 78. And we can see -- this is a scan at the level of the kidneys, and we can see the spine in the center. And we see inflammatory fluid in the retroperitoneal surrounding the right kidney. There's also consolidation and effusion at the right lung base.
Q. What's causing the effusion and the consolidation at the right lung base?
A. When you have bad pancreatitis, that's likely caused.
Q. What's the physiology -- from a physiology

standpoint, what's happening?
A. Okay. I think that would be best asked of an internist or a pancreatologist or a gastroenterologist of why that is. But these evil humors, amylase and lipase, you know, escape in the body and you can get --
Q. Inflammatory responses?
A. Right.
Q. And that is what she's having; is that right?
A. Right.
Q. If you're asked diagnostically to look at images for pancreatitis, at what stage of the pancreatitis do you see this type of inflammatory process in the lungs?
A. Actually I've never thought of it that way.
Q. I mean, is there a progression?
A. Yes, I guess the worse the degree of pancreatitis, the more of these things escape into your bloodstream. The more likely you are going to have -- find these in your lungs.
Q. I guess what you're saying to me that there's no consistent timeline for this to occur

from your experience?
A. Not that I'm aware of, but I think -- you can ask a gastroenterologist.
Q. Very good.
A. Slide number 79 --
Q. Let's stop and take a break. We've been in here for about an hour and a half.
(Whereupon, a short break was taken.)
MR. BRANDT: Back on the record.
BY MR. BRANDT:
Q. Essentially when I look at this list of the images that you looked at, it looks like you've listed studies from the time period that we're talking about, April through August. And the purpose of that is to show a worsening of her condition, is that really where you're going with that?
A. That's correct. And complications of necrotizing pancreatitis.
(Enter Dr. DeWeert.)
BY MR. BRANDT:
Q. And so as I am going through is, I'm happy if you say to me this represents a worsening of her

condition much like the film we just looked at and that way we can move forward without having you to detail everything you see in the 207 slides that we looked at.
A. Okay.
Q. Does that sound okay to you?
A. That sounds good.
Q. I mean, if that's what you're going to do to the jury -- I mean, you've already indicated to me you're not going to go through each one. Maybe what we can do is talk about the ones you are going to talk about that are demonstratively different than the one we just looked at.
A. Okay.
Q. Okay. So why don't we do that?
A. Okay. And then I have the demonstrative at the beginning, can we go --
Q. We'll get to those at the end. Okay?
A. All right.
Q. Because I want to finish up with this, the worsening of the necrotizing pancreatitis. So what are we looking at now?
A. Slide number 79, abdominal X-ray on 4/7/12, just is the plastic stent and gastro

dilatation. It doesn't show the pancreas. Chest X-ray, her chest X-rays were getting progressively better and then worse and then better and then worse.
Q. What do you relate that to, if you have an opinion?
A. I'd have to --
Q. Go back and look at her clinic pictures?
A. What's going on there, right.
Q. So you're not going to render an opinion at trial about that?
A. No, I would just say there are X-rays better on this exam, better on this -- so, no, I think that's going to be too boring.
Q. Very good.
A. And slide 63, chest X-ray --
Q. What's the date?
A. Okay. 83.
Q. 83, 3/15?
A. And 3/15, not terribly exciting, slide 84. Abdominal X-ray, slide 85 on 4/5/12. It just shows an air fluid level within the stomach and the colon is dilated. It's probably not going to show that one. 66, chest X-ray of 4/6/12. The heart looks a

little bit big. And there's some atelectasis at the lung base here. I'm probably not going to show that one.
MR. GINZKEY: That's slide 86, not 66.
THE WITNESS: And slide 87, this is 4/10/12 and --
BY MR. BRANDT:
Q. That's the chest X-ray?
A. Chest X-ray. And the lungs look worse.
Q. And by worse, you mean more atelectatic?
A. There's more atelectasis, more consolidation, more effusion. And the arrows on slide 87 show the left-sided pleural effusion. Okay. Slide number 88 --
Q. Which is a chest X-ray?
A. -- a chest X-ray on 4/12/12. And she has an endotracheal tube, which is the blue arrow. A nasogastric tube, which is the red arrow. And she's got a big degree of consolidation and effusion on the left side. Oh, I'm sorry, you're right, it's the wrong number. It's the wrong date. You are absolutely right. So actually this is August 11th, 2012.
MR. GINZKEY: It's late in the game.

THE WITNESS: Slide 88. So, yeah, forget about that. All right. So slide number 89 is the wrong date again.
BY MR. BRANDT:
Q. So what's the date of this?
A. So actually that's slide number -- 89, this is August 12th, 2012. So this is late in the game so this date is wrong.
MR. GINZKEY: It's 8/12/12 rather than --
THE WITNESS: Right.
BY MR. BRANDT:
Q. And so what is it about that? She just has more atelectasis effusion?
A. And she's got more atelectasis, congestive heart failure. She's got bilateral air space disease. So, you know, this is near the time that she died. But I have the wrong date here. So I think I'm going to have to re-do this thing and send it to you.
Q. Thank you.
A. And actually April 20th, this was a fistulogram on slide number 90. And this actually was done on 4/20/2012. And it shows communication here to a collection of the left lower quadrant

cavity. It doesn't communicate within an organ. I don't know --
Q. So --
A. Other than there was a fistula, that's all that I'm going to show.
Q. You're going to testify to the jury this image number 90, which was taken on April 20th, 2012 shows a fistulization of what?
A. Okay. There's a fistula between the skin or where this catheter is and also the peritoneal cavity here in the left lower quadrant.
Q. What's causing the fistula, do you have any opinion on that?
A. Other than, you know, this is just part and parcel of the necrotizing pancreatitis. This is one of the known complications of necrotizing pancreatitis. You get fistula and communications and abnormal fluid collections.
Q. Okay.
A. And then we're going to a CT slide on number 91 on 4/20/2012. And she's got pleural effusions at both lung bases depicted by the arrows. And again, necrotizing pancreatitis on slide number 92 between the two yellow arrows. And

then there's fluid surrounding the kidney, the bottom red arrow, and then fluid anterior to the liver, the top arrow.
Q. And the basis for the opinion that there's necrotizing pancreatitis is?
A. That, you know, I'm seeing enhancement of the pancreatic head and uncinate process but I'm not seeing enhancement of the pancreatic body and tail.
And 93 -- and also what I might do is actually show side-by-side comparisons at the same level, you know, over different dates than just showing the progression of pancreatitis and the changes of it.
And 93, again, this is April 20th, 2012, there's inflammatory change in the greater omentum. There's fluid in the lesser sac at this point. There's fluid in the intraperitoneal cavity where my red arrows are.
Q. And these are just signs of progression of her disease process?
A. That's correct. And on slide number 4 between the two red arrows lines of progression, there's more free intraperitoneal fluid down in the

pelvis. And slide number 6, again, this is April 20th, 2012, and we still have a lot of free intraperitoneal fluid in the pelvis.

Q. The abdominal CT?

A. On this abdominal CT. Chest X-ray, let's make sure of the date here. On slide number 96, this is 4/23/12. And here she's got a big heart. The red arrow is a large right-sided pleural effusion. The yellow arrow depicts a venous catheter to give her nutrition.

And, you know, there's a big heart, congestive heart failure bilateral infiltrates and effusions. And I may show a progression of what her chest X-rays looked at over a period of time.

Q. You said she had improvement and then worsening throughout the time period --

A. That's correct.

Q. -- of April through August --

A. That's correct.

Q. -- is that correct?

A. That's correct.

All right. Then slide number 97 is a scout image for the CT study done on 4/27/12, and here we can see the biliary stent.

Q. Right.

A. And then the radiologist put in a pigtail catheter in the left lower quadrant fluid collection. And that's depicted the bottom arrow.

On 98, between the two red arrows, lots of pleural effusion and pneumonia at the right lung base.

And 99, again, necrotizing pancreatitis of the body and the tail, the head. An uncinate process, you still see a little bit of it.

Q. And this is on April 27th, 2012?

A. Right.

Q. Okay.

A. And again, more of the same. We see fluid collections in the paracolic gutters. Here is the percutaneous drain, the white arrow. And on slide number 101 on 4/27/12, we're going further south. And we're seeing actually some enhancement of the peritoneal cavity so it looks like there's some peritoneal inflammation as well. And the white arrow points to the drainage catheter.

And on slide number 102, we can see the drainage catheter in the left lower quadrant, the pigtail catheter.

103, we're going further south on the study of 4/27/12, and we're seeing fluid collection of the pelvis.

And on slide number 104, I guess the patient was having diarrhea at the time so they have a rectal tube and the patient also has a Foley catheter. The rectal tube in the yellow. Foley in red.

And these are the coronal reformatted images from the same study. We can see the plastic biliary stent in yellow and the fluid collections between the two red arrows. And obviously, I'm not going to go show all these scans. I think there are too many. And again --

Q. Does this show anything different than what we just talked about, 106?

A. No.

Q. Okay. Let's go to the next one.

A. 107 shows effusions at both lung bases and pneumonia at the right lung base.

Q. And this is all April 27th, 2012?

A. Right.

Q. Okay. The next one.

A. Okay. 108 is a plain abdominal X-ray on

April 29th showing the plastic biliary drain and the percutaneous catheter in the left lower quadrant.

And on 109, this is a chest X-ray on 4/30 here. You know, she's still got a big heart and bilateral pleural effusions and consolidation of the left lung base. It looks a little bit better. She had a head CT but nothing I'm going to be talking about.

And then on 5/2/12 she had another CT, and this is a scout image on slide 111. And we can see the biliary drainage catheter. And we can see the catheter in the left lower quadrant. And the abdominal X-rays shows the same thing. And this is a CT study on 5/2/12.

I'm on slide 113. This shows more of the same. We see bilateral pleural effusions on this slide depicted by the red arrows. And then we see the necrotizing pancreatitis between the two red arrows. And then we can see fluid collections next to the right kidney.

Q. And this is May?

A. 5/2. And we're going further down. And now these -- on slide number 115 where the level of

the bottom of the kidneys, these fluid collections are getting a little bit more organized at the current term.

Q. Do you see that with necrotizing pancreatitis in your --

A. Oh, yeah.

Q. -- practice?

A. Yes. And 116, we have the drain again. 117, we have the drain going into the left lower quadrant. And 118, we're seeing that fluid collection of the pelvis but now we're getting these things, these things sticking down here. So the --

Q. You're talking about enhanced areas on slide 118 --

A. Right.

Q. -- from May 2nd, 2012 that is now something different as of May 2nd --

A. Right.

Q. -- 2012?

A. Right.

Q. What is it that's different?

A. Okay. That we're seeing these structures here, I don't know whether it's a blood clot or if

it's infection or what it is. I can't tell.

Q. Okay. It's just they're enhanced in some fashion?

A. Right. 119, nothing interesting on that. 120, chest X-ray, and it shows the patient has a -- I'm sorry, an abdominal X-ray. On 120 at 5/3/12 and shows a nasogastric tube, the biliary drain and then the percutaneous drain in yellow.

All right. And then on 121, this was a sinogram or an abscessogram performed on 5/3/12 where you inject the catheter and see where the contrast material goes. And so there's this communication here in the right upper quadrant. It doesn't feel like -- it looks like it's filling any specific organ or bowel. It just is probably related to the inflammation and, you know, the pancreatic necrosis -- or necrotizing pancreatitis.

Q. Okay. So it's showing a -- that the point of is number 121, the sinogram of 5/3/12 is to show degradation of the pancreatitis?

A. No, this does not show degradation. This is showing a collection of fluid in the right upper quadrant. So there's this fluid collection or this cavity here that's very irregular and communicates

with wherever this drain is.

Q. And the point of is what? Is this just the worsening that you're seeing?

A. Yeah, this is just the worsening. Right.

Q. Got it.

A. And more -- the same thing on slide 122. And slide number 123, here we can see a collection. This is from the same study. And this is in the right upper quadrant. So this is part of, you know, the fluid collections, cavities, abscesses that are forming following the necrotizing pancreatitis.

Q. And this is in May of 2012?

A. Right. Okay. And 124 is an abdominal X-ray showing -- now they put a drain in the right upper quadrant to drain that collection that we saw before.

Q. Right.

A. And 126 -- again, I'm not going to show all these slides, but we can see a -- and, you know, when it went down and give you the exact thing that we would be giving to the jury. And here we can see the nasogastric tube. And here is some oddly dilated segment of the small bowel.

And here we can see the patient's biliary drain and a cavity -- absence drainage cavity or fluid collection cavity drain in the right upper quadrant on 125, 126 more the same, 127, 128, 129.

130, chest X-ray on 5/4/12. Let's make sure that's correct. On 130, she has a nasogastric tube and a PICC line and some atelectasis at the right lung base. And so her chest X-ray is getting better, worse, better, worse.

And 131, 5/5 abdominal X-ray showing the same. 132. And 133, a chest X-ray from 5/6/12 and showing the big heart and the various tubes and infiltrates and effusions. And then she had another CT scan on 5/7/12, and this is a scout image showing the drain in the right upper quadrant and then the patient's pigtail catheter.

And how do I include that? That just shows the nasogastric tube going into her neck. So we're on slide 135. This is an endo lateral view of the neck done on 5/6/12.

And here we go on slide number 136. Her pleural effusions look worse now where the yellow arrows are on slide number 136. And this is May 7th of 2012. And we're seeing the pancreatic

necrosis between the two red arrows on 137.

Q. That's May 7th, 2012 also?

A. Right. 138, these collections are maturing because we can see they have a slight thickened wall in the right paracolic gutter and there's also some enhancement. So we have maturing fluid collections there. And here is the percutaneous drain in the right upper quadrant where the red arrow -- the white arrow is, and the red arrow is pointing to the necrosis.

And 139, just more of the same. 140, 141, more of the same. 142 is a chest X-ray -- abdominal X-ray on 5/12/12. Nothing exciting there. 143, the patient had an abdominal CT. And they had this device over her abdomen, because I think her abdomen was -- yeah, she had -- her abdominal wound was open at this point, her midline abdominal wound.

Q. And that's depicted on 5/15/12 --

A. Right.

Q. -- abdominal CT?

A. Right.

Q. Okay.

A. And then on 144 she's got pleural

effusions again, and this is where the surgical scar from the necrosectomy. And then we're seeing the inflammatory change on 146, 147, 148. This is a new fluid collection between the two red arrows on slide 148 on 5/15/12. And then there's the drain.

And this is just worsening of the fluid collections. And we're going through 156, 157. And there's an abscessogram or sinogram on slide 157, on slide 5/17. And here is the collection we see in the right upper quadrant.

Q. And that's on your number 158 it's a CT of the 5/17/12 and you circled something --

A. Actually it's an abscessogram. This is -- or this is a sinogram. And now we're seeing a collection in the left upper quadrant adjacent to the stomach.

Q. And that's just --

A. A new collection, right.

Q. -- a new access collection?

A. Yeah. And here 159 we see some stuff in the right lower quadrant. And then she had another CT in January -- I'm sorry, July of 2012, on July 20th, 2012. Here are the right-sided effusion

is gone but the left-sided effusion is present, and it's between the two red arrows.

Q. This is in July of 2012?

A. Yeah, July 20th, 2012 there's consolidation. And then there is a catheter. I'll put in here I don't recall if it's in the stomach or not. Okay. And just more necrosis. And so that's through slide 168.

And then they did an enema on slide number 169, which is on 7/21/12 where they put some contrast into her colon to see if it communicated with anything. And here we can see communication between the colon and this collection of the left upper quadrant.

Q. Okay. So she's got fistulization?

A. Yeah.

Q. All right.

A. And then on 7/22 -- on slide number 170 on 7/22/12, her right one looks pretty good but she's got a big effusion and some pneumonia on the left side.

Q. Okay.

A. I can't even see what that is on slide number 171, 172. They injected the collection in

right upper quadrant. And then slide 173 is the CT study of 7/24/12. And we're going through 177. And it shows worsening fluid collection.

And again, I'm not going to show all these slides. What I will do is probably do a -- maybe show a comparison, you know, at the same level, you know, how the collections or the necrosis got worse or better.

Q. Okay.

A. And then on slide number 178, this is a coronal image. And we can see she's got right upper lobe pneumonia on the CT study of 7/24/12. Okay. Now we're out of order here. And then abdominal X-ray 7/28/12. Other than just showing her drainage catheters and tubes, it doesn't show anything interesting on 160. 161 --

Q. 181.

A. 181, she has bilateral infiltrates and she's got various support lines. The same on 182, 183, 184, 185, 186, 187. And I'm not going to go show all these chest X-rays.

190. Okay. This is -- these are out of order. This is the contrast enema on slide number 190 from 7/31/12. It doesn't show much. Let's

see. On slide number 191, it does show communication with that collection of the left upper quadrant and possibly the one in the right upper quadrant.

Q. So fistulization?

A. Yeah. 193, 194, 195. 195 is a J-tube injection. They put a jejunostomy tube into Candice and on 7/30, and here is contrast injected. And nothing interesting on 196. 197. On 197, they did a vaginogram. They put contrast material within the vagina to see if it communicated with anything. 198 --

Q. I'm sorry, was there fistulization or not? We talked about that earlier.

A. Not on the ones I see now, no, 198, 199. Chest X-ray on 8/2, 200. 8/2/12 some chest X-rays. And then they injected her catheter on slide number 201 on 8/6/12, and there's communication between the stomach here.

And then she had another CT on August 8th, 2012, slide number 205. And there are bilateral pleural effusions and there's some biliary dilatation where the yellow arrow is and the stomach is dilated with fluid. And here is a

collection in the yellow arrow on slide number 207 in Morrison's pouch. And again, we're seeing all these fluid collections that look like they have matured. 209, 201.

211 is a chest X-ray. 8/9 on slide number 212. This is too much slides obviously. Slide number 213, this is a sinogram they injected a catheter in the right side of the abdomen. It's communicating with this pocket.

Q. The date is 8/9/12?

A. Right, on slide 213. 214, this is communicating with this pocket.

Q. The same date?

A. Right. And 215, 216, 217, 218 showing pretty much the same thing. On 8/12, which is slide number 219, the endotracheal tube is here and a nasogastric tube and she's got a large region of consolidation and effusion on the left. 220. Okay. So obviously I have to remove about 150 slides from here. Oh, can I show the demonstratives?

Q. Yes, that's fine. Go ahead.

A. Okay. And some of these are new and some of these you have.

Q. Okay. So let me just go back to the stuff that I have. By the way, will you send me a set of the ones we're using today?

A. And as I said, and then the one we want to show to the jury. Including the mistakes and the dates and stuff? Yeah, we might as well.

Q. Because we referred to them in the dep.

A. Yeah. Okay.

Q. So the first one I have is Page 1, which is your Page 1 also.

A. Right. And this is just to show the jury, you know, the anatomy of the abdomen. Here is the stomach and the liver, gallbladder, bile duct where the pancreas is. Slight number 2, this is what the pancreas does. You know, it injects all hormones and enzymes and bicarb. That's what the purpose of our pancreas is.

Q. Sure.

A. But I would certainly defer to a pancreatologist to give a better -- or a gastroenterologist about what it does. And this is an ERCP procedure. And this is slide number 3. And this is the gastroenterologist that they're passing the scope into the patient. And it's done

under the fluoroscope and they have one screen where they can see what's going on at the end of their ERCP scope. And then there's also a screen that shows what's going on fluoroscopically.

Q. Can I ask you a question while we're on this slide? This slide doesn't portray a radiologist present in the room?

A. That's correct.

Q. You'd agree with me the standard of care doesn't require that somebody like my client have somebody with your expertise in radiology present during the procedure?

A. That's correct.

Q. Thank you.

A. And this is what the ERCP is on slide number 4. You pass the endoscope down through the mouth through the esophagus, into the stomach, into the duodenum. And then when you get to the second portion of the duodenum, you see the papilla of Vater and then you want to check the contrast into the bile duct or pancreatic duct, whichever one you're interested in.

Q. Okay.

A. And slide number 5, this is the scope, and

then you put your catheter in the common bile duct. But unfortunately, the guidewire did not go into the bile duct. It went through the pancreas in this case.

Q. So back up a second on number 6, the red line, what's that meant to depict?

A. The trajectory of the guidewire.

Q. Okay.

A. And slide number 7 is just showing the common bile duct, the pancreatic duct, the gallbladder. Here is the head of the pancreas. And the trajectory of the guidewire was in this direction rather than into the common bile duct.

Q. The arrow is just meant to show direction?

A. Direction, correct. Not length, correct. And slide number 9 is another artist depiction of an ERCP with the intracameral in the common bile duct or if you're looking at the pancreatic duct, into the pancreatic duct. And that was just to show the trajectory of the guidewire.

Q. The red mark?

A. The red mark on 10. The same thing on 11. And just to --

Q. Number 12?

A. -- 12 what pancreatitis is.

Q. How it demonstrates pathologically?

A. I guess an artist rendition thereof. And same thing on number 137, an artist rendition of what pancreatitis is.

Q. These aren't things that you see on imaging, though; true?

A. No.

Q. Is that right?

A. No, you actually see the necrosis and you see the fluid collections but it's not colorized like that, but actually you could make pretty pictures and put colors if you want to but we don't for our purposes.

Q. Is that demonstrative?

A. Yes.

Q. So we've covered all the things that you're going to discuss and tell the jury; is that right?

A. Yes.

Q. You've acted as an expert witness before?

A. Medical expert, yes.

Q. How often?

A. Well, at trial, 27 times.

Q. Okay. How many cases do you review on an annual basis?

A. Probably one a month.

Q. How many open files do you think you have now? 24 maybe, 25, something in that area?

A. Yeah.

Q. Do you review cases for just the plaintiff or the defendants or both?

A. For both.

Q. What would be the break down plaintiff versus defendant?

A. I think throughout my career it's about two-thirds for defense, one-third for plaintiff. At the dep, the same way, but a few years it's been 50/50.

Q. And you've testified in other cases regarding pancreatitis?

A. No.

Q. There's that a case --

A. Pancreatitis at trial?

Q. Yes. Bear with me. Okay. Huettner, H-U -- you may not remember this. It's back in the '90s. H-U-E-T-T-N-E-R versus Good Samaritan Hospital, does that ring a bell with you?

A. Not at all.

Q. Okay.

A. Is that a trial?

Q. It was a deposition that you gave, testified for the plaintiff.

A. It doesn't ring a bell.

Q. How about Weland, W-E-L-A-N-D, versus Dr. Neal, do you remember that case at all? Does that ring a bell?

A. No.

Q. How about -- I'm just going to spell this, B-A-S-R-A-B, Basrab versus Northwest Community Hospital, does that ring a bell with you?

A. No.

Q. How about Swain, S-W-A-I-N, versus Mercy Hospital, does that ring a bell --

A. The name Swain but I don't recall it being pancreatitis.

Q. Bradley versus Patel, does that ring a bell with you at all?

A. No.

Q. There's a case that looks like you may have testified in the summer, Victoria versus Sonnanstein, does that ring a bell with you,

S-O-N-N-A-N-S-T-E-I-N?
A. Yeah, I think that's still open. Was that pancreatitis?
Q. I don't know what it was about. I don't have any information about it. That's why I was asking.
A. No, I don't think it was pancreatitis.
Q. You don't think it is?
A. No.
Q. Do you have any open files regarding pancreatitis?
A. Not that I recall, no.
Q. Have you ever testified in a case regarding pancreatitis?
A. Again, none comes to mind. But again, I've had quite a few cases but it doesn't come to mind.
Q. All right. What percentage of your income is derived from medical-legal matters?
A. About 15 percent.
Q. And what percentage of your time do you spend on it?
A. Well, it's night and weekends and I'm doing this today because I'm working 5:00 to 11:00

shift. So how many hours a week? It can be zero or sometimes it can be ten. Probably five hours a week or so.
Q. And are you on any services that indicate that you're available to review images for litigation?
A. I think I'm on the ISME call list.
Q. On the ISME call list?
A. Yeah. Right.
Q. Any other lists, web pages, services that provide that connect lawyers with experts?
A. Not that I'm aware of, no.
Q. You don't have any other agreements -- you don't have any agreements with any such services; is that true?
A. That's true.
Q. Do you have -- did you bring your bills with you those that you've sent to Mr. Ginzkey?
A. He has one for, you know, a retainer of a thousand dollars but that's the only one we can find.
Q. How much time have you spent in this case?
A. Going through all these, probably about 20 hours I would think at least.

Q. What's your rate?
A. $500 an hour.
Q. What's your rate for deposition?
A. $500 an hour.
Q. What's your rate for trial testimony?
A. $500 an hour.
Q. And is it a per diem if you come to Bloomington because this would be downstate?
A. No, it's the length of time I'm driving down.
Q. So 500 an hour driving down, 500 an hour in the courtroom and 500 an hour in the coming back?
A. And, you know, the night before or the day of trial, yes.
Q. So you believe twenty hours so far approximately?
A. Yeah, at least.
Q. At least?
A. Yeah.
Q. Maybe more, thirty you think?
A. No.
Q. Twenty-five?
A. I don't recall.

Q. Are you going to send him another bill today?
A. You better believe it.
Q. Okay. Has he asked you to review anything else, any other images in this case, any other --
A. No.
Q. I mean, let me ask you a better question. Do you anticipate looking at anything else? I know you're going to re-do the PowerPoint.
A. Clean it up, shorten it, brighten up some images. I don't know. If something comes up during --
Q. You don't anticipate anything today?
A. Not from my perspective, no, unless I have an epiphany, which I doubt.
Q. And in terms of the patients that you see with necrotizing pancreatitis, have some of those patients died?
A. Yes.
Q. Have there -- has their images progressed in a fashion similar to what you see here with Candice Cain?
A. Yes.
Q. And when you've been involved in those

cases, it would be a true statement that your involvement was not as a result of medical-legal but because care was being provided to the patient in real time; true?
A. That's true.
Q. And I assume that those were cases where they didn't generate a lawsuit for medical negligence, would that be true?
A. I have no way of knowing.
Q. You have no way to know?
A. Right.
Q. Truly from what you've said so far today that pancreatitis can develop without negligence; true? Without negligence on the part of the gastroenterologist?
A. Can you get pancreatitis, yes.
Q. And can that -- that can also involve necrotizing pancreatitis without negligence on the part of the gastroenterologist; true?
A. That is a complication of pancreatitis -- I mean, of the scope.
Q. Yeah, it's a known complication of ERCP; true?
A. That's correct.

A. That's correct.
Q. No indication on the MRCP -- I'm sorry, if I've asked you this. This may be a little different. No indication from the MRCP that there was fluid leaking from the pancreatic duct?
A. Well, the fluid had to come from somewhere. That's -- you know, so I'm just putting two and two together. I'm seeing pancreatic fluid so --
Q. In your opinion, it would be that it was coming from the pancreatic duct?
A. Or from the pancreas.
Q. Or the pancreas?
A. Yeah.
Q. But I'm sorry if I asked you, no evidence of contrast medium coming from the pancreatic duct or the pancreas on the MRCP done immediately after Dr. DeWeert's ERCP?
A. Again, I don't see it on the MRCP. But again, I wouldn't -- I couldn't really differentiate it on MR from just stuff related to pancreatitis. Had a CT study been done, then we could have seen if it was dense or not, but you can't tell it on the MR.

Q. Okay. With respect to the images -- and we can go back and look at those. But with respect to the images at the MRCP, can you see any extravasation of dye on the MRCP that was done immediately after Dr. DeWeert's procedure?
A. I don't recall seeing any.
Q. Okay. How is it -- is there any evidence on that MRCP of perforation?
A. Other than the fluid collection seen in the pancreas, do I see the actual hole in the pancreas?
Q. Yes.
A. No, I did not.
Q. And the same question with respect to the --
A. Nor would I typically.
Q. Understood. The same question, though, with respect to any of the imaging at Barnes when she is first admitted on 4/5 and then discharged on 4/12 -- 4/17, I'm sorry on, 2012. Anything on those images that indicates where the perforation occurred?
A. No.
Q. Nor would you expect to see it; true?

Q. The MR, you're talking about the MRCP?
A. That's right.
Q. You talked about the need to enhance the MRCP. This begs the question. If this is Cadillac equipment, why do we need to enhance it?
A. Oh, no, it's just that I photographed it too dark. That's it.
Q. So you took a photograph of the image and it just didn't come out on the PowerPoint?
A. Right. Not so much photographed it. Just downloaded the image.
Q. Okay. With respect to the intraoperative cholangiogram, and we can look at it if you need to, it did show the common bile duct dilated, didn't it?
A. Minimally, if any.
Q. And that's also seen on the MRCP; true?
A. I think at most top normal.
Q. What would be the causes of dilatation? Wouldn't a stone be a cause of dilatation?
A. Right. Oh, there are a number of causes of dilatation. You can have when you've just had a procedure done. You know, the sphincter of Oddi can be kind of spastic or kind of get edematous.

You could have it from a stone. You can have it from a blood clot in there, a parasite. You know, you can have a tumor in there as well.

Q. Did you find the intraoperative cholangiogram was -- in terms of the amount of contrast, was there an inordinate amount of contrast in the cholangiogram making these images pretty dense?

A. No. I think their diagnostic -- this doesn't look like an inordinate amount of contrast material.

Q. All right. Are gastroenterologist trained to read these images -- I'm sorry, let me ask a better question.

Are gastroenterologists trained to read MRCP?

A. No.

Q. Okay. Are gastroenterologists trained to read intraoperative cholangiogram?

A. Not specifically. But I think as part of their practice, you know, they do look at them.

Q. Okay.

A. Hopefully in consult with a radiologist.

Q. Sure. Do you know if my client was

trained to read intraoperative cholangiogram or MRCP?

A. No, I do not.

Q. With respect to your opinion on cause of death, I think I asked you this, but you're basing it on the autopsy report?

A. That's correct.

Q. There's really nothing else that you're basing it on?

MR. GINZKEY: Other than the imaging. He's already testified. That's been asked and answered. He testified he based his cause of death on the imaging and the autopsy.

BY MR. BRANDT:

Q. Is that it?

A. Yes.

Q. And we've talked about all your opinions with respect to the imaging as it relates to cause of death or is there something else you want to add?

A. No, that's it.

Q. If the ERCP at Barnes, the one that was done in April of 2012, was there any dye in the pancreatic duct, can you tell?

A. Yeah, I think there might be a contrast in the pancreatic duct here.

Q. Is there any extravasation of the dye, can you tell?

A. I can't tell.

MR. BRANDT: Let's take a break. This will help me cut the wheat from the chaff. Okay. And I'll have maybe a few more questions for you.

(Whereupon, a short break was taken.)

BY MR. BRANDT:

Q. Going through your CV you have of the same version -- well, what version do you have?

A. I guess I have the extended version.

Q. Me too. Could I have a copy of that?

A. Sure.

(Whereupon, DR. GORE Deposition Exhibit Nos. 1-2 were marked for identification.)

BY MR. BRANDT:

Q. So we're going to use this version, which is the version that I have received and it's attached to the 213 disclosures. Okay. Because

I've highlighted some publications. And it's just going to be easier if your numbers are off --

A. I don't think it will be.

Q. Okay. So we talked about the textbook of gastrointestinal radiology?

A. Right.

Q. You've indicated there was portions of those textbooks that deal with the topic that we've talked about here today; right?

A. Right, ERCP, MRCP and pancreatitis.

Q. Are there any other texts that you co-authored that deal with the subject matter?

A. I guess Editions 1 through 4 of the book and number 5 under books and monographs, Gastrointestinal High Yield Imaging, I think I talk about pancreatitis. Then I edited some Radiologic Clinics of North America and on 6 and 8 on Page Number 13 of my CV, and it would have been chapters on pancreatitis on that. I don't think I wrote those, though.

Q. Okay. Those are ones that you reviewed?

A. I edited it and were part of the monograph.

Q. Got it. The ones that I looked at -- if

you look at number 69 of your abdominal imaging.
A. Yes.
Q. Does that have anything to do with the topic matter that we've talked about today?
A. No.
Q. How about 70?
A. No.
Q. 72?
A. Boy, I wrote it so long ago, I don't know -- I suspect not.
Q. How about 79? That would seem to be on point of --
A. Yes.
Q. If you look at 117?
A. Yes.
Q. That would have something to do with what we're talking about here today; is that right?
A. Yes.
Q. 120, does that have anything to do with what we're talking about here today?
A. No.
Q. 129, does have anything to do with what we're talking about today?
A. Yes.

A. Yes.
Q. 197?
A. Yes.
Q. 201?
A. Yes.
Q. Kind of in a tangential sense; is that right?
A. Right.
Q. 242?
A. Yes.
Q. 243?
A. Yes.
Q. 246?
A. Yes.
Q. Again, kind of in a tangential perspective; is that right?
A. That's right.
Q. 260?
A. No.
Q. 287?
A. Yes.
Q. 288?
A. Yes.
Q. And 289?

Q. How about 131?
A. Yes.
Q. How about 132?
A. Yes.
Q. And 133?
A. Yes.
Q. If you go to 177, does that have anything to do with what we've been talking about here today?
A. Yes.
Q. And 182, does that have anything to do what we've been talking about here today?
A. Yes.
Q. How about 183?
A. Yes.
Q. 193, let me just -- 193 -- the question for all these is do they have anything to do with what we've been talking about today?
A. Yes.
Q. How about 194?
A. Yes.
Q. 195?
A. Yes.
Q. 196?

A. Yes.
Q. Also there's -- finally 292, does that have anything to do --
A. Tangentially as before.
Q. Anything else that you've written since or after that number I guess --
A. No.
Q. -- that deals with the pancreas or pancreatitis?
A. No.
Q. Is it true that stones can be missed on MRCP and cholangiogram?
A. Yes, they can.
Q. Okay. And have you had circumstances where you've read an MRCP or a cholangiogram and the gastroenterologist says to you later I found stones even though they were negative on those imaging?
A. Yes.
Q. Or on that imaging?
A. Yes.
Q. What is the sensitivity for common bile duct stones on MRCP?
A. I've read it in 90 percent.

Q. Do you have any opinions about what was causing her pain and discomfort before she see my client?
A. No.
Q. I think I asked you this, but you don't take care of patients clinically with pancreatitis; true?
A. No.
Q. Is that true?
A. That's correct.
Q. Did she have at the time of her -- at the time that she presented to Barnes the first time in April 2012, did she have organ failure, do you know?
A. I'd have to review the chart.
Q. As far as -- she may have? She may not have? You just don't know; is that right?
A. I don't recall.
Q. Whatever the chart says, you don't have a disagreement with; is that right?
A. That's right.
Q. Do you know if she had fluid collections when she presented to Barnes the first time?
A. Yes.

Q. She did?
A. On the basis of her CT scan, yes.
Q. And did she have pseudocysts at that time or can --
A. Well, it depends how mature they are. There were fluid collections, and I guess you call it pseudocysts when it's been mature for about four weeks.
Q. Okay. So it's in that four week period that you can actually make the call, is that what you're saying?
A. Yeah, with the new Atlanta classification.
Q. Did you look at the March 1, 2012, this would have been prior to the procedure we've been talking about, the ultrasound, did you look at that?
A. Yes.
Q. Does it show sludge in the gallbladder?
A. Yes.
Q. Do, if you know, common bile duct stones, can they move retrograde?
A. Could they move up north?
Q. Yes.
A. Yes.

Q. Patients that you are involved in where pancreatitis is the diagnosis, are you asked to consult with respect to the length of hospitalization?
A. Oh, no.
Q. Have we covered every opinion that you're going to render at trial?
A. I hope so.
MR. BRANDT: Okay. Jim, do you have some questions?
MR. GINZKEY: No questions, we'll read and sign. I would like an E-tran with the exhibits scanned in, Nancy.
MR. BRANDT: Just on the record, this is not under oath obviously at this point, but can you send me a disk of what you showed me today?
THE WITNESS: Arrows and all, you know, in terms --
MR. BRANDT: Arrows and all, yeah.
THE WITNESS: Okay.
MR. BRANDT: Just so I have that. Will you do that for me?
THE WITNESS: Uh-huh.
MR. BRANDT: And here is where you send it.

MR. GINZKEY: Actually send it to my office.
THE WITNESS: Okay.
MR. BRANDT: I would like a four to a page and PDF, please, one-sided. Can you attach the exhibits?
(Whereupon, the deposition concluded at 12:57 p.m.)
(FURTHER DEPONENT SAITH NAUGHT.)

STATE OF ILLINOIS
IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT
COUNTY OF MCLEAN

NATHAN CAIN, Independent Administrator of the Estate of CANDICE CAIN, deceased, Plaintiff, vs. THOMAS DeWEERT and DIGESTIVE DISEASE CONSULTANTS, LTD., Defendants.) Case No. 14 L 28

I, RICHARD M. GORE, M.D., being first duly sworn, on oath say that I am the deponent in the aforesaid deposition taken on August 4, 2017; that I have read the foregoing transcript of my deposition, consisting of Pages 4 through 124 inclusive, and affix my signature to same.

_____
RICHARD M. GORE, M.D.

Subscribed and sworn to
before me this _____ day
of _____, 2017.

_____
Notary Public

STATE OF ILLINOIS)
) SS:
COUNTY OF McLEAN)

I, ATHANASIA MOURGELAS, a notary public within and for the County of Cook and State of Illinois, do hereby certify that heretofore, to-wit, on the 4th day of August, 2017, personally appeared before me, at 2100 Pfingsten Road, Conference Room D, Glenview, Illinois, RICHARD M. GORE, M.D., in a cause now pending and undetermined in the Circuit Court of McLean County, Illinois, wherein NATHAN CAIN, Independent Administrator of the Estate of CANDICE CAIN, deceased, is the Plaintiff, and THOMAS DeWEERT and DIGESTIVE DISEASE CONSULTANTS, LTD., are the Defendants.

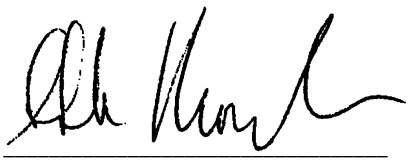
I further certify that the said RICHARD M. GORE, M.D. was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by said witness was reported stenographically by me in the presence of the said witness, and afterwards reduced to typewriting by Computer-Aided Transcription, and the foregoing is a true and correct transcript of the testimony so given by said witness as aforesaid.

I further certify that the signature to the foregoing deposition was reserved by counsel for the respective parties.

I further certify that the taking of this deposition was pursuant to notice and that there were present at the deposition the attorneys hereinbefore mentioned.

I further certify that I am not counsel for nor in any way related to the parties to this suit, nor am I in any way interested in the outcome thereof.

IN TESTIMONY WHEREOF: I have hereunto set my hand and affixed my notarial seal this 15th day of August, 2017.



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August 15, 2017
Ginzkey Law Office,
Mr. Jim Ginzkey
221 East Washington Street,
Bloomington, Illinois 61701,
IN RE: Nathan v. DeWeert, et al.
COURT NUMBER: 14 L 28
DATE TAKEN: August 4th, 2017
DEPONENT: Richard M. Gore, M.D.

Dear Mr. Ginzkey:

Enclosed is the deposition transcript for the aforementioned deponent in the above-entitled cause. Also enclosed are additional signature pages, if applicable, and errata sheets.
Per your agreement to secure signature, please submit the transcript to the deponent for review and signature. All changes or corrections must be made on the errata sheets, not on the transcript itself. All errata sheets should be signed and all signature pages need to be signed and notarized.

After the deponent has completed the above, please return all signature pages and errata sheets to me at the above address, and I will handle distribution to the respective parties.
If you have any questions, please call me at the phone number below.

Sincerely,
Cindy Alicea
Signature Department

Athanasia Mourgelas
Court Reporter
(312) 263-0052

cc: Mr. Brandt.

Exhibits

Gore Exhibit 1
Gore Exhibit 2

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