STATE OF GEORGIA

COUNTY OF \_\_\_\_\_\_\_\_\_\_\_

**AFFIDAVIT OF EXPERT, M.D., MMHC, FACS**

 Before me, the undersigned notary public, in and for County, in the State of Georgia, personally appeared Expert, M.D., MMHC, FACS who after being sworn by me, states as follows:

1.

 My name is Expert, MD, MMHC, FACS. I am over eighteen years old and of sound mind.

2.

 I obtained my medical degree at University School of Medicine in 2000. I completed my internship in General Surgery at Hospital in 2001. I completed my residency in Otolaryngology at Hospital in 2005. I completed a fellowship in Otology and Neurotology at the University-affiliated Otology Group in 2007.

3.

I have been licensed to practice medicine in Georgia since 2007, and have continuously practiced in the specialties of Otolaryngology, Otology, and Neurotology since then. I have been board certified in General Otolaryngology since 2006 and have held subspecialty board certifications in Otology and Neurotology since 2008.

4.

I served as an Assistant Professor of Otology and Neurotology at University School of Medicine from 2007 through 2015. I have served as an Associate Professor in Otology and Neurotology at the same institution since 2015. A true and correct copy of my curriculum vitae is attached hereto as Exhibit “A”.

5.

 Through my aforementioned training and practice, I have actual professional knowledge and experience regarding the medical procedures and conditions about which I give my opinions in this affidavit. Since 2007, and particularly during three out of the five years prior to April 3, 2018, I regularly and frequently performed the below described surgical procedures that I contend that Defendant Doctor inappropriately performed. I conservatively estimate that I performed the procedures on an average of 150 per year between 2013 and 2018.

6.

 I give this affidavit based on my personal knowledge and experience obtained through my education, training, clinical practice, continued review of relevant medical literature, and review of Minor Doe’s medical records, imaging studies, and other diagnostic tests from: PROVIDERS.

7.

 Ms. Doe’s medical records include the following information: On May 18, 2017, she underwent a CT of her temporal bones that was indicated because she had right-sided hearing loss, chronic ear infections, and a cholesteatoma in her left ear. The CT was interpreted as showing a “[m]oderate right-sided mastoid sinus opacity with soft tissue density posterior to the cochlear promontory which could represent cholesteatoma.” I reviewed the CT and agree with the finding.

 On April 3, 2018, Defendant Doctor performed a right canal wall down mastoidectomy, tympanoplasty, and ossicular chain reconstruction. During the course of the surgery, Defendant Doctor transected Ms. Doe’s right facial nerve with a drill, penetrated the stapes foot plate with a prosthesis that was placed into the bottom of the vestibule, created a tegmen defect with CSF otorrhea, and did not completely remove the cholesteatoma. Despite charting that “the nerve was stimulated above and below the injury with positive but diminished stimulation reported . . . The nerve itself remained physically intact”, the facial nerve was severely damaged, and Ms. Doe suffered right sided facial paralysis in addition to complete loss of hearing and likely balance in her right ear as a result of the surgery. After surgery, Ms. Doe was admitted for further evaluation. The notes do not mention the postoperative use of steroids which potentially could have reduced swelling and aided recovery.

 Dr. A, an Otolaryngologist and Neurotologist, performed a consult on Ms. Doe on April 6, 2018. Dr. A charted that Ms. Doe had total facial paralysis on her right side. According to the consult record, Defendant Doctor informed Dr. A that he was able to stimulate the facial nerve proximal to the injury. Because Defendant Doctor noted successful stimulation of the nerve, Dr. A was under the impression that the nerve was intact and suggested continued surveillance of the nerve injury rather than re-operation.

 ENT Dr. B performed a consult on Ms. Doe on April 9, 2018. Dr. B ordered high dose steroids in an attempt to reduce swelling around the facial nerve and referred Ms. Doe to Dr. C for consideration of exploration/facial nerve decompression. Additionally, Dr. B ordered a follow up CT, which was performed on April 11, 2018. The interpreting radiologist’s impression included: “Extensive postsurgical change of mastoidectomy. There is apparent retraction of residual tympanic membrane with a drainage tube questionably extending into the region of the cochlea. There is mixed density of bone at the epitympanum, as well as extending toward the hypotympanum . . .” In addition, it appeared that the ossicular prosthesis was medialized through the footplate into the vestibule.

 Dr. C performed a consult on April 13, 2018. She noted that there was no change in the facial nerve function with use of the steroids that Dr. B prescribed. Her documented impressions of the April 11, 2018 CT include the following: “ . . . soft tissue density in the middle ear and mastoid. The tegman has had interval removal from preop to postop CT in the mastoid area. There is no bone covering the facial nerve from the horizontal segment to the descending, vertical segment. There is recently placed middle ear prosthesis extending from the tympanic membrane, through the stapes footplate and to the bottom of the vestibule . . .”. Dr. C documented that an audiogram performed during the consultation showed “bone thresholds in the right ear of 15-50 dB”, and normal hearing in the left ear. Dr. C’s documented findings on exam include: “[w]ith compression of the midline forehead there is no movement or tone of the right forehead. There is normal movement of the left forehead. There is incomplete eye closure with maximum effort. There is significant scleral show . . . No midface movement or tone. With compression of the midline chin there is no movement of the right lower lip or neck. Unable to purse lips or whistle. Right face is a House Brackman 6 out 6 for motion. Left is 1/6.” Dr. C assessed Ms. Doe with right sided iatrogenic facial nerve paresis, a perilymphatic fistula, extension of a TORP (total ossicular replacement prosthesis) through the stapes footplate and into the vestibule, and right ear cholesteatoma. Her differential diagnosis included facial nerve injury including a possible facial nerve transection. Her recommendations included an EMG on the facial nerve, potential exploration of the facial nerve if the EMG showed no or poor motor activity, and observation versus removal of the TORP with patching based on the EMG results.

 The EMG was performed and showed no nerve activity consistent with a significant axonal injury to the facial nerve.

 On May 3, 2018, Dr. C performed a pre-op evaluation prior to right revision tympmastoid, PLF repair, tegmen repair, cartilage graft, possible nerve graft and greater auricular nerve graft. Ms. Doe’s right external auditory canal was filled with gelfoam. There was no right-side facial movement. Dr. C proceeded with the previously referenced surgical procedures later that day. During the course of the surgery, her findings of injuries that Defendant Doctor caused included transection of 90% of the facial nerve at the second genu with significant nerve trauma both above and below the second genu, tegmen defect measuring 8 x 10 mm with dural laceration, brain tissue extruding through the cephalocele, trauma to the brain tissue, CSF leak around the dural laceration, TORP through the stapes footplate into the vestibule. In addition, there was a foreign substance, bone wax, in the anterior epitympanum. Dr. C attempted to repair the facial nerve with a cable graft from the greater auricular nerve lateral to geniculate. Because of the profound hearing loss due to injury to the lateral canal as well as the medialized prosthesis in addition to the CSF leak, the external auditory canal was over sewn. There were no complications during the surgery.

 Ms. Doe’s facial function was unchanged following the May 3, 2018 surgery. She suffered a sensorineural hearing loss from removal of the medialized prosthesis that is permanent. When the facial nerve wasn’t appropriately starting to stimulate, Dr. C referred Ms. Doe to Specialist.

 Dr. D examined Ms. Doe at Specialist on July 25, 2018. She determined that additional grafting of the facial nerve or a cross face nerve graft could restore some of Ms. Doe’s ability to smile on the right side. Ms. Doe met with a physical therapist at Specialist during the July 25, 2018 visit. The physical therapist noted that Ms. Doe’s chief complaints were inability to smile fully, facial asymmetry, trouble drinking from a straw and a cup, trouble moving food around her mouth, trouble speaking that worsened with fatigue, inability to completely close her right eye, right eye irritability and blurry vision, social isolation, and facial pain. The physical therapist recommended focused facial rehabilitation 3-5 months after surgery.

 Dr. D and her colleague Dr. E performed a cross-face nerve graft with direct hookup from the nonparalyzed left side to the right paralyzed side on August 27, 2018. Ms. Doe is scheduled for a follow-up visit on January 22, 2018. She continued to exhibit significant right facial paresis/paralysis.

8.

In my professional medical opinion, Defendant Doctor committed multiple violations of the applicable standard of care during the April 3, 2018 surgery. His standard of care violations included transection of 90% of Ms. Doe’s right facial nerve with a drill; improper placement of the TORP such that it penetrated the stapes foot plate into the vestibule, injury to the lateral semicircular canal, and creation of a tegmen defect with dangerous and potentially life threating CSF leakage. Intra operative monitoring the facial nerve is not a substitute for proper surgical technique.

9.

In my professional medical opinion, Defendant Doctor’s violations of the standard of care caused Ms. Doe to suffer permanent injuries including right side facial paralysis, facial asymmetry, severe loss of hearing in her right ear, and disfigurement. Even with successful interventions, Ms. Doe will not ever regain full facial nerve function. These permanent injuries were unlikely to occur if Defendant Doctor had complied with the standard of care.

10.

 I hold all of my professional opinions expressed herein to a reasonable degree of medical certainty.

11.

This affidavit sets forth some of my opinions in this case and is not intended to be a summary of all of the opinions I may have. I hold all of the opinions set forth herein to a reasonable degree of medical certainty.

 Expert, M.D. MMHC, FACS

Sworn and subscribed before me

This \_\_\_ day of \_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public