CAUSE NO. 087-21

JUDY SANTERRE, Plaintiff VS. BASTROP VETERINARY HOSPITAL LARGE ANIMAL SERVICES, P.C., DR. JEFFERY SCHROEDER, DVM, DR. DARREN WEISS, DVM, DR. STEFANIE MOSLEY, DVM, AND DR. LUCY PUSTEJOVSKY, DVM, Defendants	IN THE DISTRICT COURT BASTROP COUNTY, TEXAS 21ST JUDICIAL DISTRICT

ORAL DEPOSITION OF
LUCY PUSTEJOVSKY, DVM
February 29, 2016
Volume 1

ORAL DEPOSITION OF LUCY PUSTEJOVSKY, DVM, Volume 1, produced as a witness at the instance of the Plaintiff, and duly sworn, was taken in the above-styled and numbered cause on the 29th of February, 2016, from 10:33 a.m. to 1:41 p.m., before Julie A. Jordan, CSR, RPR, in and for the State of Texas, reported by machine shorthand, at the law offices of O'Connell & Avery, LLC, 4040 Broadway, Suite 522, San Antonio, Texas 78209, pursuant to the Texas Rules of Civil Procedure and any provisions stated on the record or attached hereto.

A P P E A R A N C E S

FOR THE PLAINTIFF:

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EXHIBITS

EXHIBITS (Continued)

EXHIBITS (Continued)

LUCY PUSTEJOVSKY, DVM,

having been first duly sworn, testified as follows: 10:33AM

EXAMINATION 10:33AM

BY MS. ALLEN: 10:33AM

Q. Could you please introduce yourself to the ladies and gentlemen of the jury. 10:33AM

A. I'm Dr. Lucy Pustejovsky. 10:33AM

Q. Where do you work today? 10:33AM

A. Wharton Veterinary Clinic. 10:33AM

Q. You and I talked -- first of all, you and I have not met before today, right? 10:33AM

A. No, ma'am. 10:33AM

Q. Never had a conversation, right? 10:33AM

A. No, ma'am. 10:33AM

Q. Okay. But right before the deposition you pronounced your last name for me and I got it a little bit wrong and you said I could call you Dr. Lucy today and that would not be disrespectful. 10:33AM 10:34AM 10:34AM

Would that be all right? 10:34AM

A. Yes, ma'am. 10:34AM

Q. Okay. So, Dr. Lucy, you told us a moment ago you're now employed in Wharton, is that right? 10:34AM 10:34AM

A. Yes, ma'am. 10:34AM

Q. Okay. And out of that clinic there? 10:34AM

A. Yes. 10:34AM

Q. You're a licensed veterinarian in the state of Texas, is that right? 10:34AM

A. Yes. 10:34AM

Q. And how long have you been licensed? 10:34AM

A. May will be four years, since 2012. 10:34AM

Q. So since 2012. 10:34AM

So that we can get to know you and your background a little better, could you tell us about your educational background? 10:34AM

A. Okay. I got my bachelor's degree from Texas A&M University in 2008 in biomedical science. I got my DVM degree from Texas A&M University in 2012. 10:34AM

Q. And before that, just the regular high school stuff? 10:34AM

A. Yes, ma'am. High school in Wallace, Texas, was Brazos High School. 10:34AM

Q. And as young as you look to me, I would assume that you went straight through, is that correct? 10:35AM

A. Yes, ma'am. 10:35AM

Q. Okay. So you didn't have a job in -- you might have had part-time jobs, but you didn't stop and have a career and then go back to school? 10:35AM

A. No, ma'am. I went straight from high school, had three years undergrad and four years of vet school. 10:35AM

Q. Okay. Did you know Dr. Ashlee Watts when you 10:35AM

were there? 10:35AM

A. I did not. I think she came in right when I was about to leave. 10:35AM

Q. Okay. All right. 10:35AM

A. My work with Dr. Watson and -- I don't remember the other doctors there. 10:35AM

Q. And relative to your classmates, how did you come out in vet school? Do you know? Do you know your class rank? 10:35AM

A. I do not. 10:35AM

Q. Did you have any distinctions associated with your veterinary degree? 10:35AM

A. No, ma'am. 10:35AM

Q. Did you specialize in any areas? Did you focus your education in any particular areas? 10:35AM

A. I followed the mixed track, so half -- half large, half small type. 10:36AM

Q. And did you have courses in veterinary school that were specifically related to the treatment of equine emergencies? 10:36AM

A. Yes. 10:36AM

Q. Do you recall what classes those were? 10:36AM

A. Well, we took -- everybody took general, like, medicine courses, so your small animal, large animal, those type things, and to where emergencies are going to 10:36AM

come up, you know. I'm trying to think back the exact classes we had. And then we all take rotations through the clinic. So we spend two weeks on large animal emergency. That's in our fourth year. As well as I had a rotation in equine surgery for two weeks in large animal. So those are more time you spend exactly in the clinic. 10:36AM 10:36AM 10:36AM 10:37AM 10:37AM 10:37AM

Q. While you were doing those rotations, did you have occasion to observe or participate in cases that involved equine lacerations over a synovial joint? 10:37AM 10:37AM 10:37AM 10:37AM

A. I believe so. 10:37AM

Q. When I say "synovial joint" or "synovial structure," you know what I mean by that, right? 10:37AM 10:37AM

A. Yes, ma'am. 10:37AM

Q. The fetlock or ankle is a synovial structure, isn't it? 10:37AM 10:37AM

A. Yes. 10:37AM

Q. Okay. And that's part of the horse's front limb or back limb, front limb usually, that we would call an ankle or it looks like an ankle? 10:37AM 10:37AM 10:37AM

A. You call it a fetlock. 10:37AM

Q. Right above the hoof? 10:37AM

A. Uh-huh. 10:37AM

Q. Okay. Did you have occasion to observe what the accepted practices are for dealing with a laceration 10:38AM 10:38AM

over a synovial structure? 10:38AM

A. We had many lectures, depending on what cases came in that you saw or what you got to do hands on, but in lectures we went over treatment options, diagnostics, you know, different things you can perform. 10:38AM

Q. When -- what is your understanding of the accepted practice for managing the equine medical emergency that results from a laceration over a synovial structure? 10:38AM

A. So you mean like treatmentwise or -- 10:38AM

Q. What do you do when it walks into -- 10:38AM

A. When it walks in the door? 10:38AM

Q. -- walks in the door? 10:38AM

A. So first thing you do with any emergency, you physical exam. You assess them. If it involves a leg on an animal, you're going to want to watch it walk, taking temperature. You know, the basic vitals are important. Make sure they're not, you know, in shock or anything. And then evaluating your wound, how -- how deep does it go, where is it located, its size, any soft tissue changes, you know, drainage, you know, whatever you can visibly see. And then going from there, if you need to take -- take further diagnostics in x-ray, whatever, you know, your case warrants from there on, what the treatment -- you know, what you decide to treat 10:38AM 10:39AM 10:39AM 10:39AM 10:39AM 10:39AM 10:39AM 10:39AM

with too. 10:39AM

Q. Isn't it true that a laceration over a synovial structure is considered a special equine medical emergency that warrants a different diagnostic practice? 10:39AM

A. It can. I mean, all wounds or injuries are critical no matter where they are, but definitely joints are important. 10:39AM

Q. And isn't it true that the practice that is required when you're presented with a laceration over a synovial structure requires you to determine whether or not there is infection in the joint? 10:40AM

A. It can be important, depending how deep the wound or puncture laceration goes, whether or not the joint is involved, whether soft tissue, tendon, skin, what's affected. 10:40AM

Q. Isn't it true that you can't rule out involvement of the joint without analyzing the synovial fluid? 10:40AM

A. Yeah. In the case of showing signs of a joint problem, you're right, taking a sample and submitting it can be helpful. 10:40AM

Q. Isn't it true that any time you have a laceration over a synovial structure, there is a risk that the horse will develop a joint infection? 10:40AM

A. Definitely always a risk. Always a risk. 10:40AM

Q. You didn't see Judy Santerre's horse, Harvey, when he first came into the clinic, did you? 10:40AM

A. No, ma'am. 10:40AM

Q. Okay. 10:40AM

A. I saw him on the last visit. 10:40AM

Q. I thought it was later, and so we'll kind of move forward with that -- 10:40AM

A. Sure. 10:41AM

Q. -- in a moment when we kind of look at what you did. 10:41AM

A. Okay. 10:41AM

Q. Did you have education or training either at vet school or thereafter -- 10:41AM

A. Uh-huh. 10:41AM

Q. -- in how to analyze synovial fluid, what the proper procedures were for drawing it and analyzing it? 10:41AM

A. We -- we learned about it. I -- I had training in it. Been a while since I had done it, but there are labs you can submit it out to, including A&M, after you collect the sample if you need -- need be. 10:41AM

Q. How many times have you dealt with having -- yourself having to perform the procedures for drawing synovial fluid for analysis? 10:41AM

A. Not many. 10:41AM

Q. Once, twice? 10:41AM
A. Probably twice. 10:41AM
Q. When were those? 10:41AM
A. I observed it in veterinary school. And then in my recent job I -- I assisted with it, you know, got to see it done. Myself, I've never actually -- on a horse not actually drawn it. I've done it on a goat. 10:41AM 10:42AM 10:42AM 10:42AM
Q. Okay. So at the time that you saw Harvey -- 10:42AM
A. Uh-huh. 10:42AM
Q. -- you had never actually performed the procedure for -- 10:42AM 10:42AM
A. Not myself. 10:42AM
Q. -- drawing synovial fluid? 10:42AM
A. Uh-huh, not myself. 10:42AM
Q. Do you know whether Dr. Weiss or Dr. Schroeder had ever done that? 10:42AM 10:42AM
A. I'm not sure, but, I mean, I'm sure they have. 10:42AM
Q. At the time that you were at -- first off, did you go to Bas- -- to the Bastrop Veterinary Hospital right after you got out of school? 10:42AM 10:42AM 10:42AM
A. Yes. 10:42AM
Q. So that -- 10:42AM
A. On -- on graduation. 10:42AM
Q. That would have been in 2012? 10:42AM
A. Yes. 10:42AM

Q. Okay. And I'm not trying to pry into your personal life, but just to understand your relationship with the clinic, were you an employee of the clinic? Were you a shareholder or part of the ownership? How did that work? 10:42AM 10:42AM 10:42AM 10:42AM 10:43AM

A. I was like an associate veterinarian, so I didn't -- the two owners are Dr. Schroeder and Dr. Weiss. 10:43AM 10:43AM 10:43AM 10:43AM

Q. Okay. 10:43AM

A. And then we were, you know, hired on. 10:43AM

Q. All right. So you were an employee, is that right? 10:43AM 10:43AM

A. Yeah, yeah. 10:43AM

Q. Okay. And had benefits and that sort of thing? 10:43AM 10:43AM

A. Sure. 10:43AM

Q. Okay. And as between Dr. Weiss and Dr. Schroeder, was there one or the other of them that you were supposed to answer to or did you answer to both of them? 10:43AM 10:43AM 10:43AM 10:43AM

A. To both of them. I feel like I took on Dr. Schroeder as more of my mentor just because -- I don't know. But we -- both of them. 10:43AM 10:43AM 10:43AM 10:43AM

Q. Was there anybody else besides Dr. Weiss or Dr. Schroeder that you as an employee of Bastrop 10:43AM 10:43AM

Veterinary Hospital were to answer to? 10:43AM

A. We had an office manager, but more so about medical things, we answered to the doctors. 10:43AM

Q. Okay. 10:43AM

A. Her name was Mandy. 10:43AM

Q. And Dr. Weiss and Dr. Schroeder, they would be the ones to direct you in connection with your practice of veterinary medicine? 10:43AM

A. Sure. 10:44AM

Q. Okay. 10:44AM

A. Sure. 10:44AM

Q. At the time that you came to the Bastrop Veterinary Hospital, had you had any experience yourself in diagnosing joint issues in cases involving lacerations over a synovial joint? 10:44AM

A. Before I came there? 10:44AM

Q. Yes, ma'am. 10:44AM

A. Actually having a case of my own, I had it. I'm trying to think to what I did when I was on my two rotations I was telling you about. 10:44AM

Q. Uh-huh. 10:44AM

A. I know I studied about it, but I don't think I physically had a case that I diagnosed or did on my own. 10:44AM

Q. So then when you got out of vet school and went to the Bastrop Veterinary Hospital, did you have 10:44AM

such a case?

A. I'm trying to think. We treated wounds and lacerations fairly commonly, but as far as any of that proceeded on to, you know, a -- you know, a synovial joint or anything like that, if they -- if I did, they were mild and didn't forego any further needing treatment.

Q. They just resolved pretty quickly and that was the end of it?

A. Exactly. Just superficial wounds. Things -- you know, I definitely would see wounds all the time. And as to think of a case that had any further problems, I can't -- I can't recall one.

Q. Okay. In your experience, would you expect a laceration that you considered minor to resolve in ten days, two weeks?

A. Typically skin heals in about two weeks, yes, ma'am.

Q. So you would expect it to be noticeably better, if not well, in two weeks or so?

A. Yes, ma'am.

Q. And that would be a laceration that wasn't presenting any complications, right?

A. Usually, uh-huh.

Q. Is there -- are there exceptions to that?

10:44AM 10:44AM 10:44AM 10:45AM

A. Well, you know, some wounds take longer to heal. If you can get primary closure with stitches, right, that's the two-week, normally you're in, you're out, you're done. Depending on the size of the wound, you know, location, you know, the depth of it -- I mean, some wounds are too big to close, so they have to heal on their own. 10:45AM 10:45AM 10:46AM 10:46AM 10:46AM 10:46AM 10:46AM

You know, recently have had a case that goes six or eight weeks, you know. Just that big a piece of area is open, it's got to granulate in and heal by second attention. That takes much longer than primary closure. 10:46AM 10:46AM 10:46AM 10:46AM 10:46AM 10:46AM

Q. But if it's not getting complicated, if it's not having complications -- 10:46AM 10:46AM

A. Sure. 10:46AM

Q. -- then you shouldn't be seeing the limb swelling, getting heat in it and that sort of thing, right, during the healing process? 10:46AM 10:46AM 10:46AM

A. Yeah. The healing process, you might see a little of inflammation. That's how the body is trying to heal. But you should see -- you should note improvement. 10:46AM 10:46AM 10:46AM 10:46AM

Q. So I think I had asked you -- 10:46AM

A. Sure. 10:47AM

Q. -- prior to the time that you saw Harvey, had 10:47AM

you been involved with any those cases, and that's what you were answering, right? 10:47AM

A. Yeah. Like I said, I physically didn't have my own case that I was working up. 10:47AM

Q. Right. 10:47AM

A. But in my -- I mean, I've seen lots of lacerations. I can't think of one that comes to mind that had a joint infection that I -- you know, we went through all the motions with. 10:47AM

Q. Okay. Has -- have you ever had a circumstance, either as an observer or as a practitioner -- 10:47AM

A. Sure. 10:47AM

Q. -- where somebody brought a horse to you that you thought had a joint infection? 10:47AM

A. I have -- like I said, the goat that I treated probably within the past year had an infected -- had an infected carpal joint. 10:47AM

Q. Any horses? 10:47AM

A. No, ma'am. 10:47AM

Q. Are there any that you've observed that have been brought to a clinic you were working with or -- 10:47AM

A. Sure. Like I said, when I was at A&M, it may not have been my case, but I know I've -- I've seen -- you know, seen them, just wasn't my physical case that I 10:48AM

treated or, you know, that I was in charge of, if you will. 10:48AM

Q. Now, when a horse comes in and it has a traumatic injury, a laceration over a synovial structure, it doesn't really matter for purposes of how you're going to treat it how it happened, does it? 10:48AM

A. Not necessarily. With our patients not being able to tell us what they did, you know, it's hard to ever know exactly what happened, you know. 10:48AM

Q. Well, for example, a laceration that's made by a piece of tin you would deal with in the same way as a laceration that's made by some other piece of metal, right? 10:48AM

A. Sure. 10:48AM

Q. A laceration that's made intentionally, you'd treat the same as a laceration that was made accidentally, right? 10:48AM

A. Yeah. Sure. 10:48AM

Q. Okay. So in that sense, it really doesn't matter how it happened or who did it, right, for your purposes? 10:48AM

A. Exactly. And we normally don't know because they can't tell us, you know. Not unless someone is physically watching them when it happened. 10:48AM

Q. Okay. And that's true of Harvey's injury 10:49AM

as well, isn't it? I mean, he presented to you -- Bastrop Veterinary Hospital with a laceration over a synovial joint and it didn't really matter for y'all's purposes who did it or why they did it or how they did it, right? 10:49AM

A. Sure. Yeah. We don't -- we treat them as we see -- what we see is what we treat. 10:49AM

Q. Okay. It doesn't affect the standard of care or anything like that, right? 10:49AM

A. No. 10:49AM

Q. Okay. All right. Let me show you a couple of documents and don't know whether -- let me know if you've seen them before. 10:49AM

You know, I didn't really ask you this. Have you ever had your deposition taken before? 10:49AM

A. I have not. 10:49AM

Q. Okay. Without telling me anything that you talked about with Mr. Goldsmith over there, because I'm not asking you that, are you generally familiar with what this process is about? 10:49AM

A. Not really. 10:50AM

Q. Okay. 10:50AM

A. This is all new to me. 10:50AM

Q. Okay. Fair enough. I am here today to ask you questions to learn facts that you know about the 10:50AM

case that we have before us. 10:50AM

A. Sure. 10:50AM

Q. Okay? And the court reporter is going to take down everything that you and I say, going to put it in a booklet and it will be available for you to read. All right? 10:50AM

A. (Nods affirmatively.) 10:50AM

Q. If you need to to make it accurate, you have the right as the witness to make changes, but I want to try and see if we can minimize your need to make changes. 10:50AM

A. Sure. 10:50AM

Q. So in trying to do that, I want to be as clear and straightforward with you as I possibly can. All right? 10:50AM

A. (Nods affirmatively.) 10:50AM

Q. You'll -- and you'll have to answer verbally so that the court reporter can take down your answer. 10:50AM

A. Sure. 10:50AM

Q. Okay. I don't want to trick you. I don't want to have both of us using nomenclature that doesn't mean anything to the other one. I want us to be communicating as best that we can. Okay? 10:50AM

A. Okay. 10:51AM

Q. And to that end, if there's ever a point in 10:51AM

the deposition where I'm asking you a question that doesn't make a darn bit of sense to you, or that you cannot answer the way that I've asked it, if you'll let me know, I'll go back and change it so that it's something that you can understand. Okay? 10:51AM

A. Okay. 10:51AM

Q. And I'll probably do that from time to time. 10:51AM

And so I want to be sure that I'm not putting things in the question or trying to confuse you or anything like that. 10:51AM

A. Okay. 10:51AM

Q. This is about finding out factual information -- 10:51AM

A. Sure. 10:51AM

Q. -- that is as accurate as we can possibly make it and that's what we're here for. Okay? 10:51AM

A. Okay. 10:51AM

Q. If you ever need a break or something like that, if you'll just let me know, I'll be happy to accommodate you. And otherwise, you know, of course, you've got Mr. Goldsmith here that you can always talk to. All right? 10:51AM

A. Okay. 10:51AM

Q. Okay. 10:51AM

(Exhibits 1 through 4 marked) 10:51AM

Q. (BY MS. ALLEN) I'm going to show you some exhibits and I will mark them 1 through 4. There's some discovery responses that were filed in the lawsuit. And you take the time that you need to take a look at them -- 10:51AM 10:51AM 10:52AM 10:52AM 10:52AM

A. Okay. 10:52AM

Q. -- so that you'll know what they are. Okay? 10:52AM

MS. ALLEN: Mr. Goldsmith, in some cases I have extras for you and others I don't. 10:52AM 10:52AM

MR. GOLDSMITH: Okay. That's fine. I can look on with the witness if I need to. 10:52AM 10:52AM

MS. ALLEN: I can't explain the logic to that. It must have a logic to my staff. 10:52AM 10:52AM

MR. GOLDSMITH: If you have it, great. If not, that's fine too. 10:52AM 10:52AM

MS. ALLEN: Okay. To my staff it must be logical. 10:52AM 10:52AM

Q. (BY MS. ALLEN) Okay. So I've marked 1 through 4 some discovery responses -- 10:52AM 10:52AM

A. Okay. 10:52AM

Q. -- that were prepared and served on your behalf -- 10:52AM 10:52AM

A. Okay. 10:53AM

Q. -- in the lawsuit. And you just take a minute or however long you need to look over those and we'll 10:53AM 10:53AM

talk about them. 10:53AM

A. (Reviewing documents.) Okay. 10:53AM

Q. Have you had a chance to take a look at those? 11:00AM

A. Yes, ma'am. 11:00AM

Q. Do you recognize those as discovery responses that were served on your behalf either individually or as a group with the other veterinarians? 11:00AM

A. Yes. 11:00AM

Q. Okay. Great. 11:00AM

Could you take a look with me at Exhibit 1? 11:00AM

A. Okay. 11:00AM

Q. And that is the response to request for disclosure, is that right? 11:00AM

A. Yes. 11:00AM

Q. Okay. Could you tell me if your name is spelled correctly? 11:00AM

A. It is spelled incorrectly. 11:00AM

Q. Could you tell me how we spell your name correctly? 11:01AM

A. P-U-S-T-E-J-O-V-S-K-Y. 11:01AM

Q. P-U-S-T-E-J-O-V-S-K-Y. Is that right? 11:01AM

A. Yes, ma'am. 11:01AM

Q. Okay. So although in response to Part A you're correctly named, it's not correctly spelled, 11:01AM

CAUSE NO. 087-21

JUDY SANTERRE PLAINTIFF,	§	IN THE DISTRICT COURT
V.	§	
BASTROP VETERINARY HOSPITAL LARGE ANIMAL SERVICES, P.C., DR. JEFFERY SCHROEDER, DVM, DR. DARREN WEISS, DVM, DR. STEPHANIE MOSLEY, DVM, AND DR. LUCY PUTESJOVSKY, DVM, DEFENDANTS.	§	21ST JUDICIAL DISTRICT BASTROP COUNTY, TEXAS

DEFENDANTS' RESPONSE TO PLAINTIFF'S REQUESTS FOR DISCLOSURE

TO: JUDY SANTERRE, *Plaintiff*
By and through her attorneys of record:
Ms. Kathryn E. Allen
Mr. Christopher L. Elliott
GRAVES, DOUGHERTY, HEARON & MOODY
401 Congress Avenue, Suite 2200
Austin, Texas 78701

Defendants Bastrop Veterinary Hospital Large Animal Services, P.C., Dr. Jeffery Schroeder, DVM, Dr. Darren Weiss, DVM, Dr. Stephanie Mosley, DVM, and Dr. Lucy Putesjovsky, DVM ("Defendants") hereby serve their Response to Plaintiff's Requests for Disclosure, without waiver of Defendants' Special Exception that Plaintiff is prohibited from conducting discovery until Plaintiff amends her Petition to comply with Rule 47 of the Texas Rules of Civil Procedure:

RESPONSES TO REQUEST FOR DISCLOSURE

194.2(a) The correct names of the parties to the lawsuit.

RESPONSE:

To the best of these Defendants' knowledge, the parties are named correctly.

194.2(b) The name, address, and telephone number of any potential parties.

RESPONSE:

Hugh L. Collier
881 Cottletown Road
Smithville, Texas 78957
Telephone Unknown

Zach Padgett
838 Cottletown Road
Smithville, Texas 78957
Telephone Unknown

Mark Collier
620 Old Antioch Road
Smithville, Texas 78957
Telephone Unknown

194.2(c) The legal theories and, in general, the factual bases of Respondent's claims or defenses.

RESPONSE:

Defendants' legal theories and factual basis are contained in their Original Answer and subsequest amendments and are incorporated by reference herein.

194.2(d) The amount and any method of calculating economic damages.

RESPONSE:

At this time, Defendants are not making claim for economic damages. Defendants reserve the right to contest the amount of and method of calculating any economic damages claimed by Plaintiff.

194.2(c) The name, address, and telephone number of persons having knowledge of relevant facts, and a brief statement of each identified person's connection with the case.

RESPONSE:

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Lucy Putesjovsky, DVM
c/o O'CONNELL & AVERY LLP

194.2(f) For any testifying expert:

1. the expert's name, address, and telephone;

2. the subject matter on which the expert will testify;

3. the general substance of the expert's mental impressions and opinions and a brief summary of the basis for them, or if the expert is not retained by, employed by, or otherwise subject to the control of defendant, documents reflecting such information;

4. if the expert is retained by, employed by, or otherwise subject to the control of Defendant;

    1. all documents, tangible things, reports, models, or data compilations that have been provided to, reviewed by, or prepared by or for the expert in anticipation of the expert's testimony; and

    2. the expert's current resume and bibliography.

RESPONSE:

These Defendants have yet to designate their testifying experts. At such time as Defendants make such designation, Defendants agree to supplement this Response in accordance with the Texas Rules of Civil Procedure.

194.2(g) any discoverable indemnity and insuring agreements;

RESPONSE:

Zurich American Insurance Company
Policy No. EOL 5241302-08

194.2(h) Any settlement agreements described in Rule 192.3(g) provides that "A party many obtain discovery of the existence and contents of any relevant portions of a settlement agreement. Information concerning a settlement agreement is not by reason of disclosure admissible at trial.

RESPONSE:

At this time, these Defendants are unaware of the existence of any discoverable settlement agreements.

194.2(i) Any witness statements described in rule 192.3(h). Rule 192.3(h) provides, in pertinent part: "A party may obtain discovery of the statement of any person with knowledge of relevant facts – "a witness statement" – regardless of when the statement was made. A witness statement is (1) a written statement signed or otherwise adopted or approved in writing by the person making it, or (2) a stenographic, mechanical, electrical or other type of recording of an witness's oral statement, or any substantially verbatim transcription of such a recording. Any person may obtain, upon written request, his or her own statement concerning the lawsuit, which is in the possession, custody or control of any party.

RESPONSE:

At this time, these Defendants are unaware of the existence of any discoverable witness statements.

194.2(j) In a suit alleging physical or mental injury and damages from the occurrence that is the subject of the case, an authorization permitting the disclosure of all medical records and bills that are reasonably related to the injuries or damages asserted;

RESPONSE:

Not applicable.

194.2(k) If this is a suit alleging physical or mental injury and damages from the occurrence that is the subject of the case, produce all medical records and bills obtained by the responding party by virtue of an authorization furnished by the requesting party.

RESPONSE:

At this time, these Defendants are not in possession of any medical records or bills responsive to this Request. If in the future Defendants obtain such records, Defendants agree to supplement this response in accordance with the Texas Rules of Civil Procedure.

194.2(l) Produce the name, address, and telephone number of any person who may be designated as a responsible third party.

CERTIFICATE OF SERVICE

I hereby certify that a true, full and correct copy of the foregoing instrument has been forwarded this 14th day of August, 2015 *via facsimile or certified mail, return receipt requested,* to the following counsel of record:

Ms. Kathryn E. Allen
Mr. Christopher L. Elliott
GRAVES, DOUGHERTY, HEARON & MOODY
401 Congress Avenue, Suite 2200
Austin, Texas 78701

KEITH B. O'CONNELL
JAMES W. GOLDSMITH, JR.

CAUSE NO. 087-21

JUDY SANTERRE	§	IN THE DISTRICT COURT
PLAINTIFF,	§	
	§	
V.	§	
	§	
BASTROP VETERINARY HOSPITAL	§	21ST JUDICIAL DISTRICT
LARGE ANIMAL SERVICES, P.C.,	§	
DR. JEFFERY SCHROEDER, DVM,	§	
DR. DARREN WEISS, DVM,	§	
DR. STEPHANIE MOSLEY, DVM, AND	§	
DR. LUCY PUTESJOVSKY, DVM	§	
DEFENDANTS.	§	BASTROP COUNTY, TEXAS

CERTIFICATE OF WRITTEN DISCOVERY

TO THE HONORABLE JUDGE OF SAID COURT:

In compliance with Rule 191.4(a) of the Texas Rules of Civil Procedure, on this date Defendants Bastrop Veterinary Hospital Large Animal Services, P.C., Dr. Jeffery Schroeder, DVM, Dr. Darren Weiss, DVM, Dr. Stephanie Mosley, DVM, and Dr. Lucy Putesjovsky, DVM served the following discovery:

1. Defendants' Response to Plaintiff's Requests for Disclosure.

This discovery, along with a copy of this Certificate of Written Discovery, was served on the parties listed below in the Certificate of Service.

Respectfully submitted,

O'CONNELL & AVERY LLP

By: _____

KEITH B. O'CONNELL
State Bar No. 15179700
JAMES W. GOLDSMITH, JR.
State Bar No. 24051570

4040 Broadway Street, Suite 522
San Antonio, Texas 78209
Telephone: (210) 824-0009
Facsimile: (210) 824-9429

ATTORNEYS FOR DEFENDANTS
BASTROP VETERINARY HOSPITAL
LARGE ANIMAL SERVICES, P.C.,
DR. JEFFERY SCHROEDER, DVM,
DR. DARREN WEISS, DVM,
DR. STEPHANIE MOSLEY, DVM, AND
DR. LUCY PUTESJOYSKY, DVM

CERTIFICATE OF SERVICE

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Ms. Kathryn E. Allen
Mr. Christopher L. Elliott
GRAVES, DOUGHERTY, HEARON & MOODY
401 Congress Avenue, Suite 2200
Austin, Texas 78701

_____
KEITH B. O'CONNELL
JAMES W. GOLDSMITH, JR.

correct? 11:01AM

A. Yes. Just -- just misspelled. 11:01AM

Q. Okay. So we need to change the spelling there and get the spelling right. 11:01AM

A. Yes. 11:01AM

Q. Okay. And then -- and some of this may be legalese that you do or don't know about, but I just have to ask you. So Part B asks about any potential parties, and there are some people who are named there. 11:01AM

Do you see that? 11:01AM

A. Yes. 11:01AM

Q. Do you have any idea why they might be potential parties in this lawsuit? 11:01AM

A. Do they think that's where the wound came from? 11:01AM

Q. Well, I don't know. Do you? 11:01AM

A. I mean, I don't know any of these names, but they're all near her address. 11:01AM

Q. Would it matter for purposes of the work that the veterinarians did who inflicted the injury? 11:02AM

A. No. 11:02AM

Q. Would it matter where the injury was inflicted? 11:02AM

A. No. 11:02AM

Q. Would it matter whether they -- whoever did it 11:02AM

did it on purpose or did it by accident? 11:02AM

A. No. 11:02AM

Q. Okay. Is there any other connection to this case that you know or suspect that these folks might have? 11:02AM

A. I do not. 11:02AM

Q. Okay. There's a vet listed here, Heidi Moore. 11:02AM

A. Yes. 11:02AM

Q. Do you know Heidi Moore? 11:02AM

A. Yes. She worked at the clinic as an associate while I was there. 11:02AM

Q. Did she treat Harvey? 11:02AM

A. I believe in our medical records she might have sent home medicine. I believe. 11:02AM

Q. Okay. All right. And is there anybody else -- now with the benefit of hindsight and some passage of time and maybe refreshing your recollection, is there anybody else besides the people on this list that you think might have knowledge of facts concerning Harvey's treatment? 11:03AM

A. No, ma'am. 11:03AM

Q. Okay. Which is Exhibit 2, if you could help us out. 11:03AM

A. This is the objections and answers to the first set of interrogation. 11:03AM

CAUSE NO. 087-21

JUDY SANTERRE	§	IN THE DISTRICT COURT
	§	
PLAINTIFF,	§	
	§	
V.	§	
	§	
BASTROP VETERINARY HOSPITAL	§	21ST JUDICIAL DISTRICT
LARGE ANIMAL SERVICES, P.C.,	§	
DR. JEFFERY SCHROEDER, DVM,	§	
DR. DARREN WEISS, DVM,	§	
DR. STEPHANIE MOSLEY, DVM, AND	§	
DR. LUCY PUTESJOVSKY, DVM	§	
	§	
DEFENDANTS.	§	BASTROP COUNTY, TEXAS

DEFENDANT DR. LUCY PUTESJOVSKY, DVM'S OBJECTIONS AND ANSWERS TO PLAINTIFF'S FIRST SET OF INTERROGATORIES

To: **Judy Santerre, Plaintiff**
By and through her attorneys of Record
Ms. Kathryn E. Allen
Mr. Christopher L. Elliott
GRAVES, DOUGHERTY, HEARON & MOODY
401 Congress Avenue, Suite 2200
Austin, Texas 78701

COMES NOW, Dr. Lucy Putesjovsky, Defendant in the above-styled and numbered cause and submits this her Objections and Answers to Plaintiff's First Set of Interrogatories as follows:

INTERROGATORY NO. 1: Please provide the name, address and telephone number of each person providing answers or assisting in providing answers to these interrogatories.

ANSWER: Dr. Jeffery Schroeder, DVM
Dr. Darren Weiss, DVM
Dr. Stefanie Mosely, DVM
Dr. Lucy Putesovskey, DVM
c/o O'CONNELL & AVERY LLP
Keith B. O'Connell
James W. Goldsmith, Jr.
4040 Broadway Street, Suite 522
San Antonio, Texas 78209
Telephone: (210) 824-0009

INTERROGATORY NO. 2: Pursuant to Rule 192.3(d), Texas Rules of Civil Procedure, please provide the name, address and telephone number of each person you expect to call as a trial witness in this case.

ANSWER: Defendant objects to this Interrogatory for the reason that it is unreasonably cumulative or duplicative. Defendant further objects to this Interrogatory for the reason that it is premature. Discovery is just beginning in this cause, and Defendant has yet to identify its trial witnesses. Defendant will identify its trial witnesses in accordance with the local rules of Court and with the Rules of Civil Procedure, and supplement this Answer accordingly. Subject to the foregoing and without waiving same, please refer to Defendant's Response to Plaintiff's Request for Disclosure.

INTERROGATORY NO. 3: Pursuant to Rule 192.3(b), please identify the location and custodian for all Bastrop Veterinary Hospital ("BVH") records pertaining to, illustrating or discussing in any manner the treatment at BVH of Plaintiff Judy Santerre's horse, Harvey.

ANSWER: All such records are in the possession of Defendant's counsel, and have been produced in response to Plaintiff's Request for Production.

INTERROGATORY NO. 4: Please state the date on which you claim to have reasonably anticipated litigation in this matter.

ANSWER: August 19, 2014.

INTERROGATORY NO. 5: Please state the factual basis for your contention that Judy Santerre was "contributorily negligent" regarding the death of her horse, Harvey. See page 2, § II.B.1 of Defendants' Special Exception and Original Answer.

ANSWER: Large temporal gaps in treatment and in physically presenting Harvey for examination. Unknown at this stage of discovery whether Plaintiff applied medications as instructed.

INTERROGATORY NO. 6: Please identify all conditions precedent to Plaintiff's causes of action that you allege have not been performed or have not occurred as of the date of your answer to this interrogatory.

ANSWER: Such contention was cured with Plaintiff's First Amended Petition. Defendant no longer alleges such a defense.

INTERROGATORY NO. 7: Please identify each and every person employed by or otherwise affiliated with BVH who provided treatment or assistance of any kind to Judy Santerre's horse, Harvey, and the manner of treatment and/or assistance provided by each person you identify.

ANSWER: Defendant objects to this Interrogatory for the reason that it is unreasonably collective or duplicative. All persons who provided treatment and assistance are identified in the documents produced in response to Plaintiffs Request for Production, along with the details of such treatment and/or assistance.

INTERROGATORY NO. 8: Please identify by day of the week and month every instance in the years 2013 and 2014 in which anyone at BVH provided treatment and/or assistance to Judy Santerre's horse, Harvey and as to each such instance, the condition of Harvey's right front ankle when such treatment and/or assistance was given.

ANSWER: Defendant objects to this Interrogatory for the reason that it is unreasonably collective or duplicative. All dates of treatment and descriptions of Harvey's condition are identified in the documents produced in response to Plaintiffs Request for Production.

INTERROGATORY NO. 9: Please list each diagnosis given Harvey's condition when treated at BVH in the years 2013 and 2014.

ANSWER: Defendant objects to this Interrogatory for the reason that it is unreasonably collective or duplicative. All diagnoses are identified in the documents produced in response to Plaintiffs Request for Production.

INTERROGATORY NO. 10: Please state each method of treatment prescribed for Harvey for any condition for which he was seen at BVH in the years 2013 and 2014.

ANSWER: Defendant objects to this Interrogatory for the reason that it is unreasonably collective or duplicative. All methods of treatment are identified in the documents produced in response to Plaintiffs Request for Production.

INTERROGATORY NO. 11: Please state your new worth as of the date of your answer to this interrogatory.

ANSWER: Defendant objects to this Interrogatory for the reason that it is neither relevant nor reasonably calculated to lead to the discovery of admissible evidence. Defendant further objects to this Interrogatory for the reason that it seeks information that is personal, confidential and/or proprietary in nature. Subject to the foregoing objections and without waiving same, defendant agrees to supplement this Response.

Respectfully submitted,

O'CONNELL & AVERY LLP

By: _____
KEITH B. O'CONNELL
State Bar No. 15179700
JAMES W. GOLDSMITH, JR.
State Bar No. 24051570

4040 Broadway Street, Suite 522
San Antonio, Texas 78209
Telephone: (210) 824-0009
Facsimile: (210) 824-9429

ATTORNEYS FOR DEFENDANTS

CERTIFICATE OF SERVICE

I hereby certify that a true, full and correct copy of the foregoing instrument has been forwarded this 9th day of October, 2015 *via facsimile or certified mail, return receipt requested,* to the following counsel of record:

Ms. Kathryn E. Allen
Mr. Christopher L. Elliott
GRAVES, DOUGHERTY, HEARON & MOODY
401 Congress Avenue, Suite 2200
Austin, Texas 78701

_____
KEITH B. O'CONNELL
JAMES W. GOLDSMITH, JR.

CAUSE NO. 087-21

JUDY SANTERRE	§	IN THE DISTRICT COURT
	§	
PLAINTIFF,	§	
	§	
V.	§	
	§	
BASTROP VETERINARY HOSPITAL	§	21ST JUDICIAL DISTRICT
LARGE ANIMAL SERVICES, P.C.,	§	
DR. JEFFERY SCHROEDER, DVM,	§	
DR. DARREN WEISS, DVM,	§	
DR. STEPHANIE MOSLEY, DVM, AND	§	
DR. LUCY PUTESJOVSKY, DVM	§	
	§	
DEFENDANTS.	§	BASTROP COUNTY, TEXAS

DEFENDANT DR. LUCY PUTESJOVSKY, DVM'S OBJECTIONS AND RESPONSES TO PLAINTIFF'S FIRST REQUESTS FOR ADMISSIONS

To: **Judy Santerre, Plaintiff**
By and through her attorneys of Record
Ms. Kathryn E. Allen
Mr. Christopher L. Elliott
GRAVES, DOUGHERTY, HEARON & MOODY
401 Congress Avenue, Suite 2200
Austin, Texas 78701

COMES NOW, Dr. Lucy Putesjovsky, DVM, Defendant in the above-styled and numbered cause and submits this her Objections and Responses to Plaintiff's Requests for Admissions as follows:

REQUEST FOR ADMISSION NO. 1: Judy Santerre's horse "Harvey" was a patient at the Bastrop Veterinary Hospital ("BVH") in September of 2013.

RESPONSE: Admit.

Putesjovsky 3
EXHIBIT NO.
2-29-16
Julie A. Jordan

REQUEST FOR ADMISSION NO. 2: Dr. Jeffrey Schroeder provided veterinary services to Harvey during his stay at BVH in September of 2013.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 3: Dr. Darren Weiss provided veterinary services to Harvey during his stay at BVH in September 2013.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 4: Dr. Stefanie Mosley provided veterinary services to Harvey during his stay at BVH in September 2013.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 5: Dr. Lucy Putesjovsky provided veterinary services to Harvey during his stay at BVH in September 2013.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 6: Harvey was suffering from a cut in his right front ankle area when he was brought to BVH in September of 2013.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 7: When Harvey was brought to BVH for treatment in September of 2013, one or more veterinarians represented to Judy Santerre that BVH and its doctors were capable of properly treating Harvey's injury.

RESPONSE: Denied.

REQUEST FOR ADMISSION NO. 8: When Harvey was brought to BVH for treatment in September of 2013, no doctor at BVH told Judy Santerre that BVH and its doctors were incapable of properly treating Harvey's injury.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 9: It is common knowledge in the field of veterinary medicine that puncture wounds or lacerations on a limb over or near a joint or tendon sheath commonly result in joint infections in mature horses.

RESPONSE: Denied.

REQUEST FOR ADMISSION NO. 10: One or more of Harvey's treating veterinarians at BVH knew at the time Harvey was being treated in September of 2013 that puncture wounds or lacerations on a limb over or near a joint or tendon sheath commonly result in joint infections in mature horses.

RESPONSE: Denied.

REQUEST FOR ADMISSION NO. 11: After Harvey was first brought in for treatment at BVH in September of 2013 and before he was released to go home, no veterinarian at BVH took steps to prevent or detect a joint infection in Harvey's right front ankle.

RESPONSE: Denied.

REQUEST FOR ADMISSION NO. 12: After Harvey was released from BVH to return home with Judy Santerre, Ms. Santerre contacted BVH by telephone and informed one or more veterinarians at BVH that Harvey's right front ankle had swelled and was draining a thick, yellowish fluid.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 13: Swelling and drainage of yellowish fluid from a horse's ankle joint is a sign of infection.

RESPONSE: Denied.

REQUEST FOR ADMISSION NO. 14: Swelling and drainage of yellowish fluid from a horse's ankle joint may be a sign of infection.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 15: After Harvey's release from BVH after his treatment there in September of 2013, Judy Santerre sent photographs of Harvey's right front ankle to BVH.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 16: The photographs of Harvey's right front ankle that Judy Santerre sent to BVH after Harvey's release from treatment at BVH in September of 2013 showed Harvey's swollen right front ankle joint and yellowish discharge coming from the joint.

RESPONSE: Denied.

REQUEST FOR ADMISSION NO. 17: On November 8, 2013, Judy Santerre brought Harvey to BVH for further evaluation.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 18: When Harvey arrived at BVH on November 8, 2013, his right front ankle was swollen and he was lame.

RESPONSE: Denied.

REQUEST FOR ADMISSION NO. 19: On November 8, 2013, when Judy Santerre brought Harvey to BVH, she asked Dr. Lucy Putesjovsky, DVM, if Harvey had a joint infection in his right front ankle joint.

RESPONSE: Denied.

REQUEST FOR ADMISSION NO. 20: On November 8, 2013, in response to a question from Judy Santerre, Dr. Lucy Putesjovsky told Judy Santerre that Harvey did not have a joint infection in his right front ankle joint.

RESPONSE: Denied.

REQUEST FOR ADMISSION NO. 21: On November 8, 2013, no one at BVH took a sample of joint fluid from Harvey's right front ankle joint.

RESPONSE: Denied.

REQUEST FOR ADMISSION NO. 22: On November 8, 2013, no one at BVH ordered blood work to be done with regard to Harvey's right front ankle joint.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 23: On November 8, 2013, no one at BVH ordered ultrasonography tests be done on Harvey's right front ankle joint.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 24: On November 29, 2013, Judy Santerre brought Harvey back to BVH for evaluation.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 25: On November 29, 2013, when Judy Santerre brought Harvey back to BVH for further evaluation, he had a badly swollen right front ankle joint and was Grade 4 lame.

RESPONSE: Denied.

REQUEST FOR ADMISSION NO. 26: On November 29, 2013, at least one veterinarian working at BVH told Judy Santerre that Harvey did not have a joint infection in his right front ankle joint.

RESPONSE: Denied.

REQUEST FOR ADMISSION NO. 27: On November 29, 2013, one or more veterinarians at BVH put a sweat wrap on Harvey's right front ankle and sent him home with Judy Santerre.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 28: On November 29, 2013, no one at BVH performed joint lavage on Harvey's front right ankle joint.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 29: On November 29, 2013, no one at BVH administered intravenous antibiotics to Harvey.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 30: On November 29, 2013, no one at BVH administered local antibiotics to Harvey.

RESPONSE: Denied.

REQUEST FOR ADMISSION NO. 31: On November 29, 2013, no one at BVH performed an arthroscopy on Harvey's right front ankle joint.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 32: A sweat wrap is contraindicated for treatment of a joint infection in a mature horse.

RESPONSE: Denied.

REQUEST FOR ADMISSION NO. 33: Harvey was diagnosed in December of 2013 with a joint infection in his right front ankle joint by one or more veterinary professionals at Texas A&M University in College Station, Texas.

RESPONSE: Admit.

Respectfully submitted,

O'CONNELL & AVERY LLP

By: _____

KEITH B. O'CONNELL
State Bar No. 15179700
JAMES W. GOLDSMITH, JR.
State Bar No. 24051570

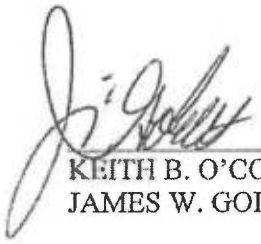
4040 Broadway Street, Suite 522
San Antonio, Texas 78209
Telephone: (210) 824-0009
Facsimile: (210) 824-9429

ATTORNEYS FOR DEFENDANTS

CERTIFICATE OF SERVICE

I hereby certify that a true, full and correct copy of the foregoing instrument has been forwarded this 9th day of October, 2015 *via facsimile, first class mail, or certified mail, return receipt requested,* to the following counsel of record:

Ms. Kathryn E. Allen
Mr. Christopher L. Elliott
GRAVES, DOUGHERTY, HEARON & MOODY
401 Congress Avenue, Suite 2200
Austin, Texas 78701



KEITH B. O'CONNELL
JAMES W. GOLDSMITH, JR.

CAUSE NO. 087-21

JUDY SANTERRE	§	IN THE DISTRICT COURT
	§	
PLAINTIFF,	§	
	§	
V.	§	
	§	
BASTROP VETERINARY HOSPITAL	§	21ST JUDICIAL DISTRICT
LARGE ANIMAL SERVICES, P.C.,	§	
DR. JEFFERY SCHROEDER, DVM,	§	
DR. DARREN WEISS, DVM,	§	
DR. STEPHANIE MOSLEY, DVM, AND	§	
DR. LUCY PUTESJOVSKY, DVM	§	
	§	
DEFENDANTS.	§	BASTROP COUNTY, TEXAS

DEFENDANT DR. LUCY PUTESJOVSKY, DVM'S OBJECTIONS AND RESPONSES TO PLAINTIFF'S FIRST REQUEST FOR PRODUCTION

To: **Judy Santerre, Plaintiff**
By and through her attorneys of Record
Ms. Kathryn E. Allen
Mr. Christopher L. Elliott
GRAVES, DOUGHERTY, HEARON & MOODY
401 Congress Avenue, Suite 2200
Austin, Texas 78701

COMES NOW, Dr. Lucy Putesjovsky, DVM, Defendant in the above-styled and numbered cause and submits this her Objections and Responses to Plaintiff's First Request for Production as follows:

REQUEST FOR PRODUCTION NO. 1: Copies of any and all records generated by Bastrop Veterinary Hospital ("BVH") related to the treatment at BVH of Judy Santerre's horse, Harvey, in the years 2013 and 2014.

RESPONSE: Documents responsive to this Request are being served contemporaneously with this Response.

REQUEST FOR PRODUCTION NO. 2: Copies of all bills sent to Judy Santerre for veterinary services provided to Ms. Santerre's horse, Harvey, in the years 2013 and 2014.

RESPONSE: Documents responsive to this Request are being served contemporaneously with this Response.

Putesjovsky 4
EXHIBIT NO.
2-24-16
Julie A. Jordan

REQUEST FOR PRODUCTION NO. 3: Copies of any and all records in BVH's possession or control related to treatment of Judy Santerre's horse, Harvey, at any veterinary medicine facilities other than BVH, including, but not limited to, Texas A&M University, during the years 2013 and 2014.

\

RESPONSE: Documents responsive to this Request are being served contemporaneously with this Response.

REQUEST FOR PRODUCTION NO. 4: Copies of any and all written communications, including electronic communications, between BVH and Texas A&M University concerning Judy Santerre's horse, Harvey.

RESPONSE: Documents responsive to this Request are being served contemporaneously with this Response.

REQUEST FOR PRODUCTION NO. 5: Copies of any articles, textbook entries, learned treatise entries, or other written material in your possession, including electronic material, regarding proper recognition of joint infections in mature horses.

RESPONSE: Despite a diligent search, Defendant has been unable to identify responsive documents within its possession, custody, or control.

REQUEST FOR PRODUCTION NO. 6: Copies of any articles, textbook entries, learned treatise entries, or other written material in your possession, including electronic material, discussing proper treatment of joint infections in mature horses.

RESPONSE: Despite a diligent search, Defendant has been unable to identify responsive documents within its possession, custody, or control.

REQUEST FOR PRODUCTION NO. 7: Copies of all written communication between anyone at BVH and Judy Santerre regarding treatment of her horse, Harvey, in the years 2013 and 2014.

RESPONSE: Documents responsive to this Request are being served contemporaneously with this Response.

REQUEST FOR PRODUCTION NO. 8: Copies of any reports, notes or writings of any kind comprising, reflecting or discussing all internal investigations, evaluations or other analyses of

Judy Santerre's horse, Harvey, in the years 2013 and 2014 which were compiled prior to the date you assert that you reasonably anticipated litigation in this matter.

RESPONSE: Documents responsive to this Request are being served contemporaneously with this Response.

REQUEST FOR PRODUCTION NO. 9: Copy of a recent balance sheet, profit and loss statement, statement of net worth prepared for a financial institution or other reliable financial instrument or writing which accurately states your net worth as of the date of your response to this request for production.

RESPONSE: Defendant objects to this Request for the reason that it is not relevant nor reasonably calculated to lead to the discovery of admissible evidence. Defendant further objects to this Request for the reason that it seeks information that is personal, confidential and/or proprietary in nature. Subject to the foregoing objections and without waiving same, Defendant agrees to supplement this Response.

Respectfully submitted,

O'CONNELL & AVERY LLP

By: _____
KEITH B. O'CONNELL
State Bar No. 15179700
JAMES W. GOLDSMITH, JR.
State Bar No. 24051570

4040 Broadway Street, Suite 522
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ATTORNEYS FOR DEFENDANTS

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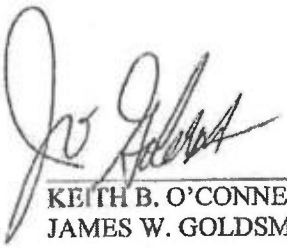


KEITH B. O'CONNELL
JAMES W. GOLDSMITH, JR.

Q. Interrogatories maybe? 11:03AM
A. Interrogatories, yeah. 11:03AM
Q. You get to have vet speak. I get to have lawyer speak. 11:03AM
A. There you go. I'll give that to you. 11:03AM
Q. Gladly, I bet. 11:03AM
A. Yes, ma'am. 11:03AM
Q. All right. In the beginning at Interrogatory No. 1 we asked who helped answer some interrogatories, and listed on your behalf was Dr. Schroeder, Dr. Weiss, Dr. Mosley and yourself. 11:03AM 11:04AM
Do you see that? 11:04AM
A. Uh-huh. 11:04AM
Q. Who participated in the answering of which interrogatories? Can you remember? 11:04AM
A. No. I think it -- wasn't it a combination? 11:04AM
Q. Well, okay. Let me ask it this way maybe. 11:04AM
Do you know how -- did you sit down and write out answers to these interrogatories? 11:04AM
A. No. I believe I spoke with him on the phone (indicating). 11:04AM
Q. Okay. Again, I'm -- I don't want to ask you about conversations that you had with your attorneys. Okay? I'm not trying to ask you that. 11:04AM
A. Okay. 11:04AM

Q. I'm just trying to ask whether there were other people with input in your answers. That's all I'm trying to get to. 11:04AM

A. Okay. 11:04AM

Q. Do you know? 11:04AM

A. No. I mean, it was just the people involved. 11:04AM

Q. And those were the -- that's Schroeder, Weiss, Mosley and yourself? 11:04AM

A. Weiss, Mosley, and me. Uh-huh. 11:04AM

Q. Okay. And again, without -- I don't want to know the substance of these communications, if there were any, but did you kind of sit down and talk through it or -- 11:04AM

A. We each contacted him -- him individually. 11:05AM

Q. Okay. All right. Are you comfortable with all the answers that are in here or are there any that you would change or tweek if you had an opportunity to do it? 11:05AM

A. I'm comfortable, yeah. 11:05AM

Q. Okay. Would you look with me on Page 2 at Interrogatory No. 5 and the answer that you see there? 11:05AM

A. Uh-huh. (Reviewing document.) 11:05AM

Q. What is meant by "large temporal gaps in treatment" in this answer? 11:05AM

A. I guess the fact that such a long period of 11:05AM

time took place between examinations. 11:05AM

Q. And what was the long period of time that took place? 11:05AM

A. I don't have a -- the dates in front of me, but I know he came in and he got stitches and he came back for a recheck like planned. That would have got us to the beginning of October. And then I believe there was another exam in between, between October and the end of November, I believe. 11:05AM 11:06AM 11:06AM 11:06AM

Q. Well, let's ask it this way. Are you -- 11:06AM

A. Sure. 11:06AM

Q. Are you critical of Ms. Santerre for not bringing him in often enough or for not contacting the clinic often enough? 11:06AM 11:06AM

A. She did send e-mails with his pictures. 11:06AM

Q. How many times did she bring him in? 11:06AM

A. I believe four or -- three or four times. 11:06AM

Q. Over the course of how long? 11:06AM

A. Two and a half months. 11:06AM

Q. And so where was the large temporal gap in treatment? 11:06AM 11:06AM

A. I guess just the fact that if you were getting worse and he didn't come in sooner rather than later. 11:06AM 11:07AM

Q. When should she have brought him in that she didn't? 11:07AM 11:07AM

A. I mean, I guess instead of, you know, waiting, maybe should have came back right away if he wasn't improving as soon as we started the medicine, those type things. 11:07AM

Q. Did anybody ever tell her that, to your knowledge, bring him back right away if he's not better tomorrow or the next day? 11:07AM

A. I'm not sure. 11:07AM

Q. You don't know of anybody telling her that, do you? 11:07AM

A. I'm not sure what -- what their conversations were. I did read through medical notes they, you know, wrote down, but it would be my concern is if he wasn't getting better, maybe we should change something, he should come back, those type. 11:07AM

Q. You as a veterinarian would have that concern, right? 11:07AM

A. Yes, ma'am. 11:08AM

Q. What I'm trying to get to is whether, to your knowledge, anybody at Bastrop Veterinary Hospital communicated that to Ms. Santerre? 11:08AM

A. I'm not sure what their conversations were. I would -- I would hope they did. 11:08AM

Q. How about you? Did you communicate to her, If he's not better tomorrow or the next day, you bring him 11:08AM

back?

A. I did. I did. When I saw him on the 29th, my concern was this has gone on two and a half months. It's a long time for a wound. We -- we talked about that. And I noted he should go to a specialist. Obviously he had been coming to see us for two months, and so I told her we would do something to get him through the weekend. I wanted her to call me Monday. If he wasn't better, we would send him to a specialist.

Q. And she did, right?

A. Yes, ma'am.

Q. Okay. So there was no gap in treatment there. She did exactly what you told her to do, right?

A. Yes, ma'am.

Q. Are you aware of any occasion on which Judy Santerre didn't do just exactly what the vets at Bastrop Veterinary Hospital told her to do?

A. You know, I'm not sure what they told her, but, I mean, she had the medications we gave her. I would assume she gave them, but, you know, we don't know.

Q. Do you have any reason to think she didn't give medications just exactly the way the vets at Bastrop Veterinary Hospital told her to give them?

A. Like I said, I'm not sure, you know, how she

gave the medicines or what she gave, but surely she was doing treatment at home. 11:09AM

Q. To the best of your knowledge, she gave the medicines exactly the way the vets at Bastrop Veterinary Hospital told her to give them, didn't she? 11:09AM

A. Hopefully. 11:09AM

Q. You don't know any different, do you? 11:09AM

A. No. 11:09AM

Q. Okay. Is there any large temporal gap in treatment that you could point to to say, Here's where he got worse, any at all? 11:09AM

A. Well, he never got better, so -- well, like, I don't know if he ever got better. But, I mean, for two months he just kind of -- you know, he -- I don't know if he got better or got worse ever, but he just went on a long period of time with a wound, you know, that should have healed. 11:09AM 11:10AM

Q. Was the discussion that you had with Ms. Santerre about a specialist, to the best of your knowledge, was that the first time anybody at Bastrop Veterinary Hospital ever suggested that Harvey needed to be referred elsewhere? 11:10AM

A. I wouldn't think so. But then again, like I said, I wasn't there for that conversation. 11:10AM

Q. You looked through the treatment notes and you 11:10AM

didn't see anything like that in the treatment notes, did you? 11:10AM

A. I didn't notice anything. 11:10AM

Q. To the best of your knowledge, apart from the original injury that brought him in the door back in September 2013 -- 11:10AM

A. Uh-huh. 11:10AM

Q. -- there was no new injury or new trauma to that area, was there? 11:10AM

A. No. 11:10AM

Q. There was no reason -- no explanation for the fact that in November it was swollen and it wasn't -- even though it had healed on the outside, it was swollen and inflamed -- 11:10AM

A. Uh-huh. 11:11AM

Q. -- there was no explanation for that other than an infection, was there? 11:11AM

A. There can be many causes for it. Infection is always a rule-out, a possibility. It could have been soft tissue injury, scarring, you know, inflammation to the local structures. There's many things that could be going on. The concern was, I mean, going that long and not getting better. 11:11AM

Q. Did you suspect he had a joint infection on November 29th of 2013? 11:11AM

A. That was definitely a possibility. 11:11AM

Q. And you put that in your treatment notes, in fact, didn't you? 11:11AM

A. Uh-huh. 11:11AM

Q. You kind of have to say yes or no or she's not sure what your answer is. 11:11AM

A. Oh. Yes. 11:11AM

Q. Okay. Did you tell Ms. Santerre that you thought or suspected that he might have a -- that Harvey might have a joint infection back on November 29th of 2013? 11:11AM

A. That's why I told her I wanted to refer him. 11:12AM

Q. Because you couldn't deal with a joint infection? 11:12AM

A. Because I wanted to get further diagnostics done, that I felt more comfortable him going to a specialist. 11:12AM

Q. What diagnostics had been done at Bastrop Veterinary Hospital? 11:12AM

A. He had been examined multiple times and had x-rays taken and I believe that's all. 11:12AM

Q. Do you know what the diagnostic protocol is for a joint infection? 11:12AM

A. Typically with a joint infection, definitely you can take x-rays, you can ultrasound the region, you 11:12AM

can perform a joint tap, culture -- culture it. Different things can be done. 11:12AM

Q. Anything besides the three things that you just mentioned that you are aware of that are accepted protocols for a joint infection -- suspected joint infection? 11:12AM

A. Anything else? 11:12AM

Q. Yes. 11:12AM

A. Those are the most common things. 11:12AM

Q. What's the only one of those three that's going to tell you one way or the other whether or not there's bacteria in the synovial fluid? 11:13AM

A. Oh, by evaluating the synovial fluid. 11:13AM

Q. That's by -- 11:13AM

A. I told you -- 11:13AM

Q. -- tapping the joint? 11:13AM

A. Uh-huh. 11:13AM

Q. And that was never done at Bastrop Veterinary Clinic, right? 11:13AM

A. It was not. 11:13AM

Q. Why not? 11:13AM

A. I guess at the time the -- what we were seeing wasn't -- all the signs we were seeing weren't showing up as a classic infection. And so I guess we were treating it, and then once I saw it, I knew I wanted to 11:13AM

send it to a referral and I knew they would do it. It was just, you know, unfortunate it was already that far down -- down the road. 11:13AM

Q. You're aware that it is accepted practice that joint infections or joint lacerations have to be treated aggressively and very quickly in order to have a prognosis that's even somewhat positive, right? 11:13AM 11:13AM 11:13AM 11:14AM

A. Yes. They're serious injuries. 11:14AM

Q. And promptly means within 24 hours, right? 11:14AM

A. I mean, as soon as possible. 11:14AM

Q. Well, I mean, if it can be done within 24 hours, that's what you want to do, right? 11:14AM 11:14AM

A. Sure. 11:14AM

Q. And it could have been done at Bastrop Veterinary Hospital, right? The proper diagnostic procedure to tap the joint and to culture the synovial fluid, that could have been done, right? 11:14AM 11:14AM 11:14AM

A. Yes. 11:14AM

Q. And it could have been done within 24 hours of Harvey's first walking in the door, right? 11:14AM 11:14AM

A. Yes. 11:14AM

Q. Why wasn't it done? 11:14AM

A. I think at that point they examined the wound and it didn't seem to extend. There was no joint fluid coming out. It didn't seem -- the wound didn't seem to 11:14AM 11:14AM 11:14AM

communicate with the joint and the worry probably was taking in infection with it, because any time you poke a needle in, you run the risk of infecting the joint. And so conservative method I bet was taken trying to avoid that. 11:14AM 11:14AM 11:15AM 11:15AM 11:15AM

Q. You don't know the protocol for tapping a joint when you have a wound? 11:15AM 11:15AM

A. Sterile prep and -- yeah, definitely, you know, clip, clean, sterile prep around it and doing it, but it's always a concern. 11:15AM 11:15AM 11:15AM

Q. There's an accepted protocol that's used all the time -- 11:15AM 11:15AM

A. Uh-huh. 11:15AM

Q. -- to draw synovial fluid out of a joint where you've got a laceration over a synovial structure, right? 11:15AM 11:15AM

A. Yes. 11:15AM

Q. And it's used all the time because if it's done properly, it's safe to do, right? 11:15AM 11:15AM

A. Uh-huh. 11:15AM

Q. You have to say yes or no. 11:15AM

A. Yes. 11:15AM

Q. Did you ever speak with Dr. Mosley, who did see Harvey when she first -- when he first came in, about why she did not follow this accepted protocol that 11:15AM 11:15AM 11:15AM

is used all the time? 11:15AM

A. I did not. 11:15AM

Q. Did you ever ask her why when Harvey first came in with a laceration over a synovial structure, she did not even x-ray him? 11:15AM

A. I did not. 11:16AM

Q. And you know she didn't ultrasound him either, right? 11:16AM

A. Yes. 11:16AM

Q. Did you ever talk with her about why she didn't ultrasound him? 11:16AM

A. I did not. 11:16AM

Q. But it is crystal clear that this horse came into the Bastrop Veterinary Hospital with a laceration over a synovial structure and it was unknown origin and unknown how long it had happened, right? 11:16AM

A. Yes. 11:16AM

Q. That had the risk of having a joint infection associated with it, right? 11:16AM

A. It's always a risk. 11:16AM

Q. And not a single one of the accepted protocols for determining whether or not there was joint involvement was followed, is that right? 11:16AM

A. Yes. 11:16AM

Q. And, in fact, as far as I can tell, the only 11:16AM

time even a single one of those steps was taken was a time when there were two x-rays shot. 11:16AM

Do you remember that? 11:16AM

A. That was, I believe, in November. One of the visits in November. 11:16AM

Q. Well, let me ask it to you this way, open-ended. 11:16AM

Are you aware of any time when even a single one of the diagnostic steps that might have been taken were taken other than these two radiographs that were shot at one point in time? 11:17AM

A. No. 11:17AM

Q. But you know about the two radiographs, right? 11:17AM

A. Yes. 11:17AM

Q. Did you ever look at them? 11:17AM

A. I believe I did when he came in -- when I saw him when he came -- they were previously taken. 11:17AM

Q. We'll look at it in a minute, but your notation says something like NSF. I know what that means to a bank, but I don't know what it means to you. 11:17AM

A. No significant findings. 11:17AM

Q. So the radiographs didn't tell you anything, right -- 11:17AM

A. No. 11:17AM

Q. -- as a diagnostic tool? 11:17AM

A. No.

Q. Was there a reason you didn't use one of the other diagnostic tools to determine whether or not there was a joint involvement? 11:17AM

A. You're right, should have took the next step. I was planning on referring him, that they would. I could have attempted ultrasound. Our machine isn't as high quality as theirs, but I could have attempted that or taken a sample. 11:17AM 11:18AM

Q. What kind of x-ray machine did the clinic have at the time these x-rays were taken of Harvey? 11:18AM

A. A digital, a nice x-ray system. 11:18AM

Q. And when you say NSF or no significant findings concerning the x-rays, what does that mean? 11:18AM

A. It means that from what I saw, I didn't see anything abnormal enough to warrant, you know, anything major that I saw there. And I just rechecked what was already in their system. 11:18AM

Q. For a joint infection, if there had been joint involvement -- which we know there was, right, because A&M found that, right? 11:18AM

A. But it may not have been at that time. 11:18AM

Q. Okay. And here's what I'm trying to understand is -- 11:18AM

A. Sure. 11:18AM

Q. -- when you look at an x-ray for purposes of using it as a diagnostic tool for -- 11:18AM
A. Uh-huh. 11:18AM
Q. -- a joint infection or possible joint infection -- 11:18AM
A. Sure. 11:19AM
Q. -- what is it you're looking for? 11:19AM
A. When you're looking at an x-ray, you're looking for changes along the bone structure, lysis. Obviously you can see swelling. But any changes along the -- the bone surfaces there. Changes in the narrowing or difference of the spacing, those are things you can look for. 11:19AM
Q. Changes in the bone structure, how long would that take to show up? 11:19AM
A. You'd think after a couple of weeks you would see some changing. 11:19AM
Q. Okay. And you saw none? 11:19AM
A. I didn't notice any. 11:19AM
Q. Okay. How about -- and -- okay. 11:19AM
You didn't take your own x-rays, right? 11:19AM
A. I didn't repeat them, no, ma'am. 11:19AM
Q. Okay. Why not? 11:19AM
A. That's a good question. I guess since I didn't see anything there, I didn't repeat them, but it 11:19AM

had been a few weeks. 11:19AM

Q. So you might have seen something had you repeated them, correct? 11:19AM

A. It's possible. 11:19AM

Q. Okay. Because that's how bone changes work. They progress over time, right? 11:19AM

A. Yes, ma'am. 11:20AM

Q. Okay. And then you said something about the space might be different. 11:20AM

A. Uh-huh. 11:20AM

Q. Do you remember that? 11:20AM

A. Uh-huh. 11:20AM

Q. Explain to us what you meant by that. 11:20AM

A. Well, sometimes you can see, you know, compression or widening of the space depending on pressure inside the joint capsule. 11:20AM

Q. If you see compression of the space, does that indicate pressure inside the joint capsule? 11:20AM

A. It can. Anything abnormal would clue you in. 11:20AM

Q. Did you go back to see what Dr. Mosley had thought of the x-rays or did you speak with her about it, about if she had concluded anything about the x-rays? 11:20AM

A. I don't -- I don't believe so, because probably if she were there, she would have saw the horse 11:20AM

because it was her case. I would guess, but I'm not sure. It's so long ago. 11:20AM 11:20AM

Q. Okay. Is there any respect in which you would say sitting here today that Judy Santerre failed to follow the veterinarians' instructions or did something that caused her horse further damage? 11:20AM 11:21AM 11:21AM

A. Not that I know of. 11:21AM

Q. Okay. Or didn't do something that she should have done. Is there anything like that that you know of? 11:21AM 11:21AM 11:21AM

A. Like we talked earlier, could she have brought it in more frequently? I mean, that's the only thing I can think of. 11:21AM 11:21AM 11:21AM

Q. Okay. 11:21AM

A. Or gone to specialist earlier. 11:21AM

Q. Well, now, in fairness, whose job is it to tell Judy Santerre that she needs to go to a specialist? 11:21AM 11:21AM

A. Oh, definitely her referring veterinarian. 11:21AM

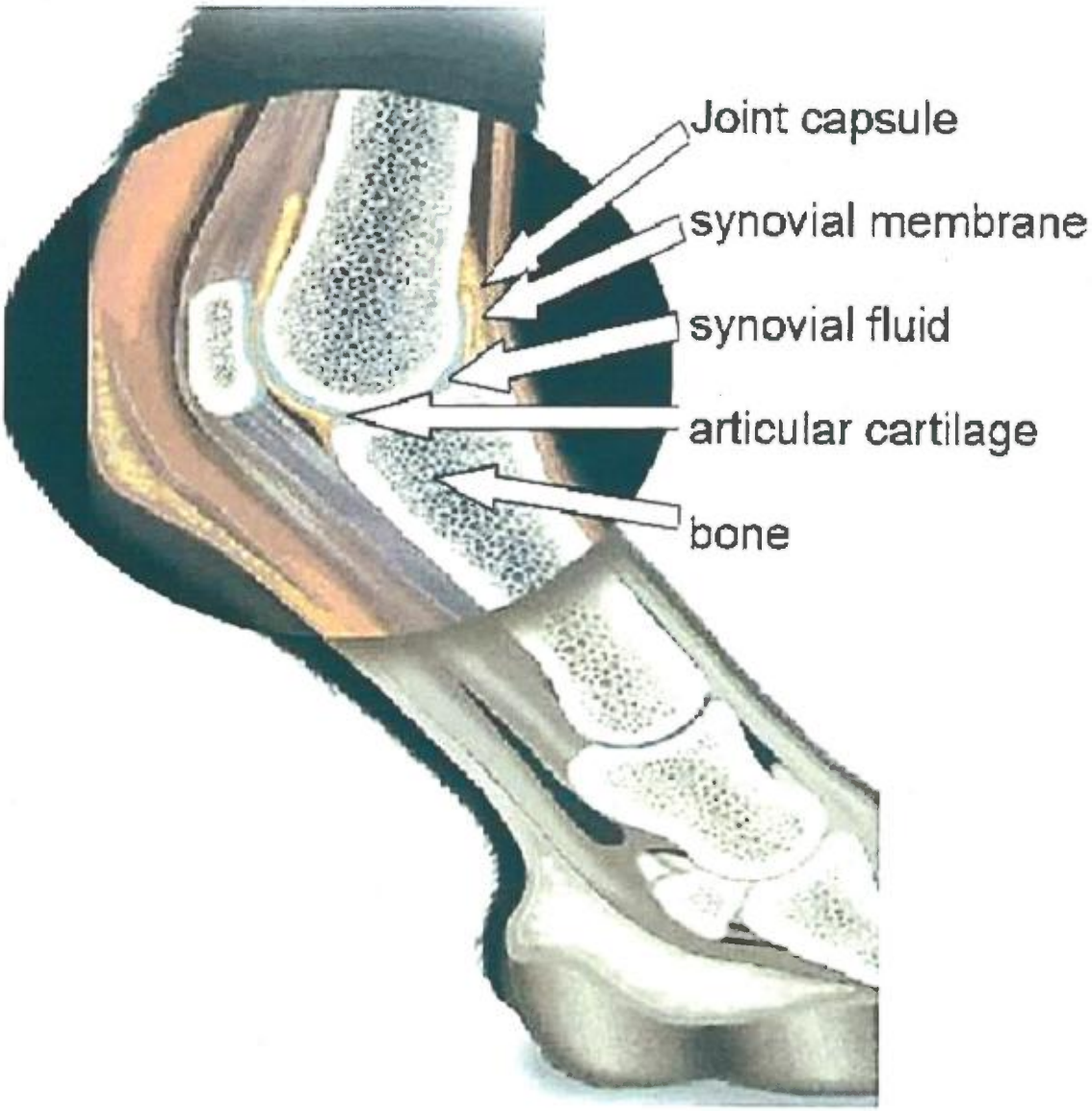
Q. That would be the vets at Bastrop Veterinary Hospital's -- 11:21AM 11:21AM

A. Uh-huh. 11:21AM

Q. -- job, right? 11:21AM

A. Yes. 11:21AM

Q. Okay. And the first time that that was ever done was when? 11:21AM 11:21AM



A. Well, I know I -- when I told her, but I'm not sure if anybody else told her anything. 11:21AM

Q. Well, you looked through the treatment notes and you know that -- 11:21AM 11:22AM

A. Oh, yeah. I didn't see anything in the notes. 11:22AM

Q. -- there's nothing in there and you know that she kept on coming back to Bastrop Veterinary Hospital, right? 11:22AM 11:22AM

A. Uh-huh. Yes. 11:22AM

Q. And you know that nobody said, Hey, what are you doing here? You need to be over at Elgin or A&M or something like that, right? 11:22AM 11:22AM

A. Yes. 11:22AM

Q. So as far as you know, the first time anybody ever told Judy Santerre that she needed a specialist is when you did it, is that right? 11:22AM 11:22AM

A. Yes. 11:22AM

Q. Okay. Let's put those aside for the moment and not worry about them further right now. Let me show you Exhibit 5. 11:22AM 11:22AM

(Exhibit 5 marked) 11:22AM

Q. (BY MS. ALLEN) Which is just nothing more than a sketch that I pulled off the Internet. 11:22AM 11:23AM

A. Oh, okay. 11:23AM

Q. I'm not saying that that's Harvey, but is that 11:23AM

a typical fetlock joint? 11:23AM

A. Yes, it's a diagram of a fetlock. 11:23AM

Q. And it's showing the synovial fluid and the synovial membrane in the joint, right? 11:23AM

A. Uh-huh. 11:23AM

Q. Okay. And you can see the joint capsule, that kind of yellow -- 11:23AM

A. Uh-huh. 11:23AM

Q. -- thing that's going up on both sides of the bone, right? 11:23AM

A. Yes. 11:23AM

Q. And that's the concern when you get a laceration is if it's in the proximity of that joint capsule, that's how the infection gets in there, right? 11:23AM

A. Anything that enters, yes. 11:23AM

Q. And that's why that's a concern is when it's anywhere near the joint capsule, then you have that risk? 11:23AM

MR. GOLDSMITH: Form. 11:23AM

A. It's possible. Yes. 11:23AM

Q. (BY MS. ALLEN) And Harvey's injury was on top of the joint capsule, wasn't it? 11:23AM

A. It was on the latter aspect of the skin above the fetlock. 11:24AM

(Exhibit 6 marked) 11:24AM

Q. (BY MS. ALLEN) Well, I know that you didn't see him when he walked in the door, but we have some pictures. I'm going to show you Exhibit 6. 11:24AM

MS. ALLEN: I'll mark a few here. And 7 and 8 and 9 and 10. 11:24AM

(Exhibits 7 through 10 marked) 11:24AM

Q. (BY MS. ALLEN) And 6 through 8 are showing the wound -- 11:24AM

A. Uh-huh. 11:24AM

Q. -- which is right on top of the fetlock joint, isn't it? 11:24AM

A. Yes. 11:25AM

Q. And then 9 and 10 are showing where they sutured on top of the fetlock joint, right? 11:25AM

A. Yes. 11:25AM

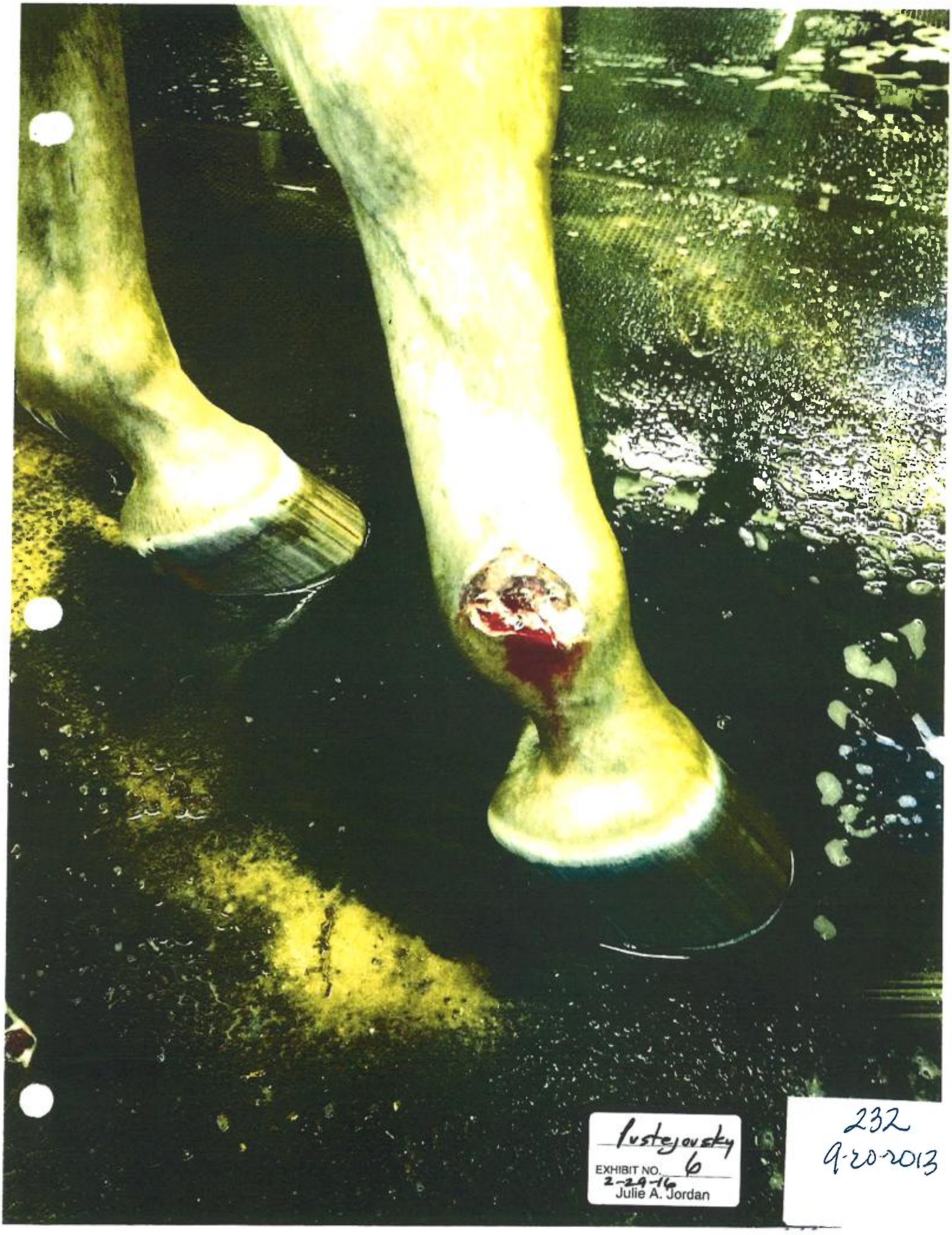
Q. So somebody actually did stick a needle in his leg near the fetlock joint that day, correct? 11:25AM

A. Yes. 11:25AM

Q. Okay. And that's the kind of wound that is a special circumstance that requires the special protocol for ruling out joint involvement, right? 11:25AM

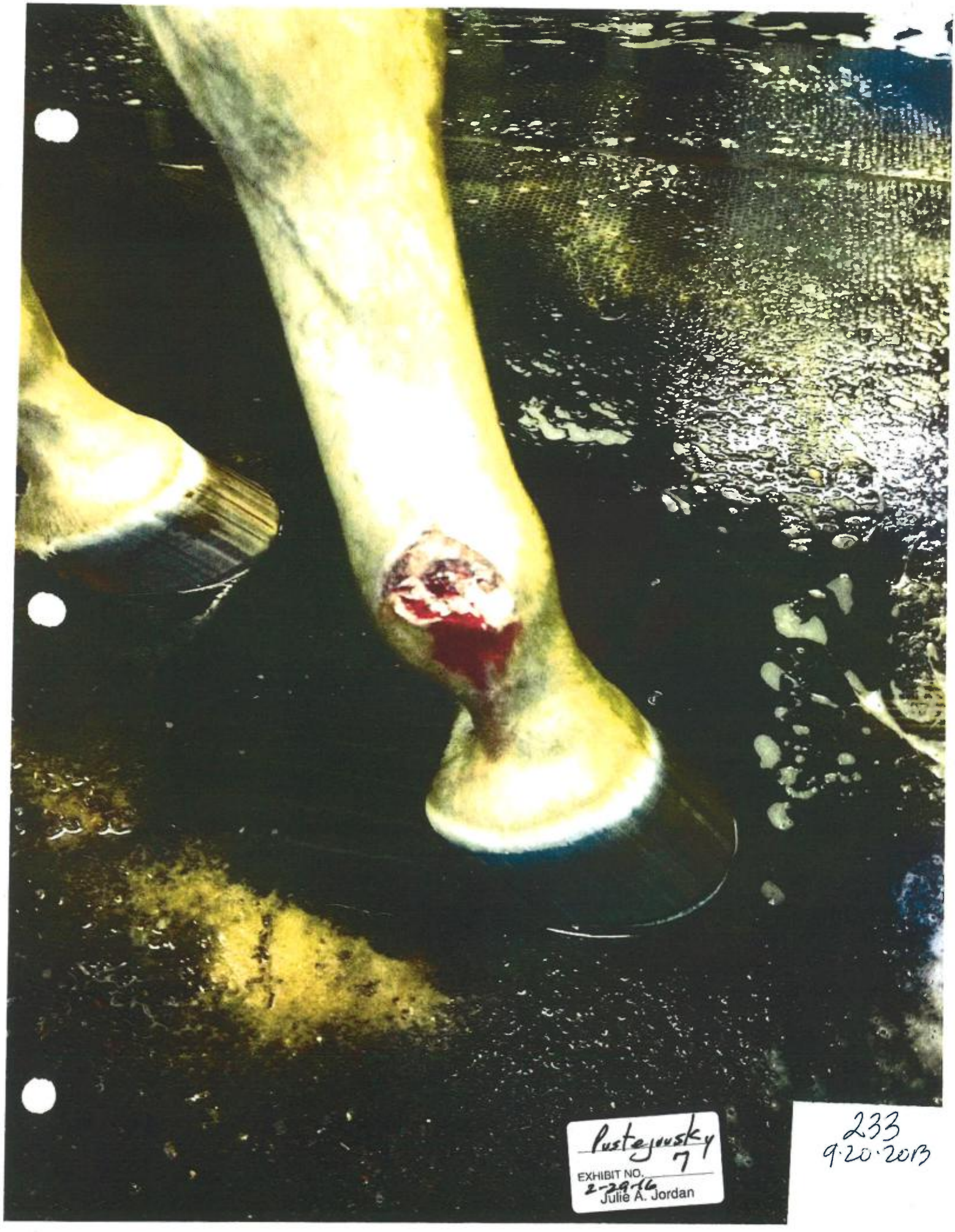
A. Yes. 11:25AM

Q. Now, you referred a minute ago to your treatment notes or to the treatment notes. Hang on. I think -- 11:25AM



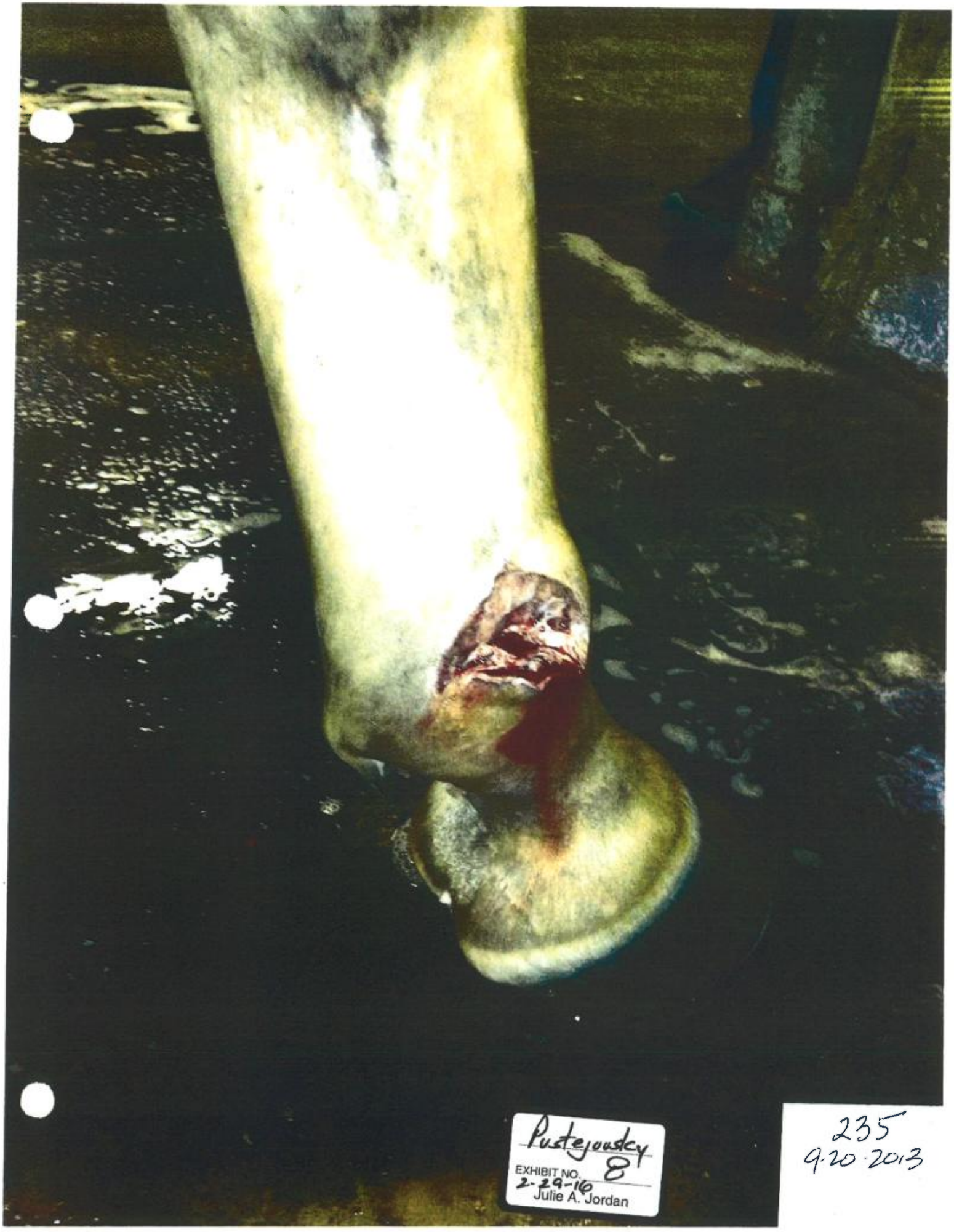
Rustejovsky
EXHIBIT NO. 6
2-29-16
Julie A. Jordan

232
9-20-2013



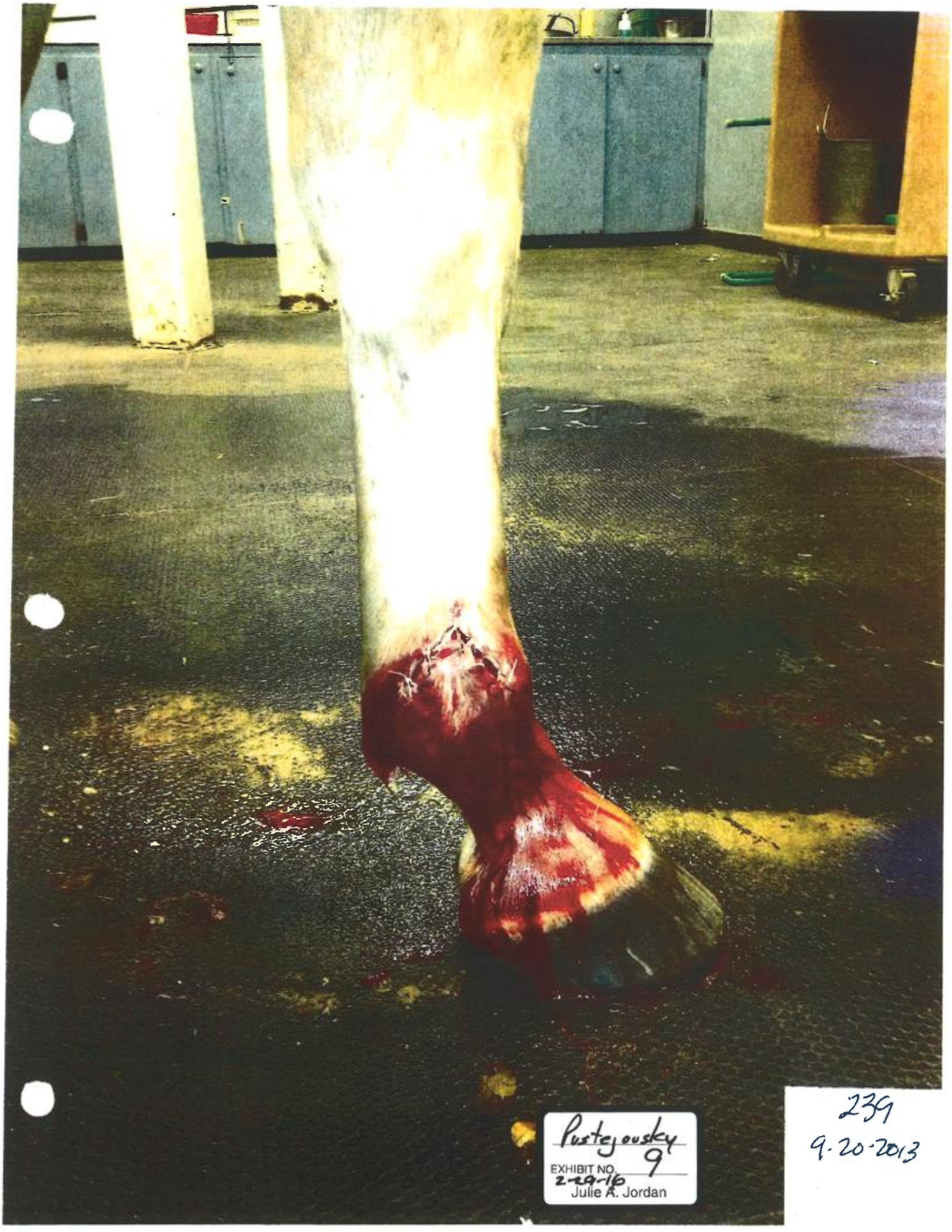
Pustejovsky 7
EXHIBIT NO.
2-29-16
Julie A. Jordan

233
9.20.2013



Pustejovsky 8
EXHIBIT NO.
2-29-16
Julie A. Jordan

235
9-20-2013



Pustejovsky 9
EXHIBIT NO.
2-29-16
Julie A. Jordan

239
9-20-2013

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9-20-2013

(Exhibit 11 marked) 11:25AM

Q. (BY MS. ALLEN) Let me see if I've marked as Exhibit 11 what you were referring to. 11:25AM

A. Yeah. These are the records from -- from Bastrop Vet. 11:25AM

Q. And tell us what is -- what is the record that we're looking at? It is a record maintained by the vet clinic, right? 11:26AM

A. The vet clinic, yes. 11:26AM

Q. And what kind of record is it? 11:26AM

A. Medical record. 11:26AM

Q. So is this something that are the notes of the veterinarians as they provide the treatment? 11:26AM

A. Yes. 11:26AM

Q. How is this document -- in the timeframe that it was prepared, which is late 2013, September, October, November and December 2013 -- 11:26AM

A. Uh-huh. 11:26AM

Q. -- what was the process for preparing the patient history document? 11:26AM

A. I'm confused. 11:26AM

Q. How did -- did you type it into a computer or -- 11:26AM

A. Oh, yeah. We have a Cornerstone program. It's a medical record template, takes care of our 11:26AM

Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Breed: Quarter Horse, American
Age: 12 Yrs. 8 Mos.
Sex: Gelding
Color: Cream/Palomino

Date	Type	Staff	History

12/11/2013 C LP NOTES - FINAL

REFERRED TO DR. WATTS-CALLED WITH UPDATE. RECHECK RADS- NOTED ENTHESOPHYTES AND LYSIS ON MARGINS OF THE PROXIMAL SESMOIDS.
SEPTIC JOINT. SYNOVIUM THICKENED, JOINT WASH. 98% NEUTROPHILS.
12/4 SURGERY-FLUSHED JOINT, VERY COLLAPSED AND FILLED WITH FIBROUS TISSUE. CARTILAGE THIN, NO OSTEOMYLITIS. JOINT OPEN AND DRAINING, COVERED IN STERILE BANDAGE. TX WITH AMIKACIN.
1ST DAY POSTOP SEEMS MORE COMFORTABLE JUST ON 1 GRAM BUTE.
P:LAVAGE JOINT EVERY FEW DAYS. DISCUSSED WITH O MAY STILL BE LAME WITH SEPSIS RESOLVED, MAY NEED TARSAL ARTHRODESIS LATER ON.

12/17 UPDATE- DOING MUCH BETTER, LAMESNESS MUCH IMPROVED. STOPPED THE EOD JOINT FLUSHING ON 12/13, NOW JUST BANDAGING AND WAITING FOR ARTHROTOMY SITES TO HEAL. SEVERE ARTHRITIC CHANGES, JOINT NOT DISTENDED. CURRENTLY ON IV K-PEN AND GEN, 1 GRAM BUTE BID AND BANDAGE CHANGES.

11/29/2013 C LP RECHECK EXAM NOTES - FINAL

HX-LIMPING HAS GOTTEN WORSE AND MORE SWOLLEN. SKIN WOUND IS HEALING. O HAS BEEN GIVING BANAMINE 10CC SID FOR 4 DAYS BUT STILL PAINFUL AND HAS BEEN BANDAGING IT WITH JUST VET WRAP. KEEPING STALLED UP.

PE:T100.6 BAR. EYES WNL. BCS 6/9. H/L-WNL, CLEAR. GUT SOUNDS NORMAL. MS-GRADE 3/5 LAME RIGHT FRONT, WORSE WHEN FIRST STARTS MOVING. THE WOUND ON FETLOCK IS PRETTY WELL HEALED, JUST SCAR. MOD-SEVERE SWELLING ON THE LATERAL ASPECT OF FETLOCK, EXTENDING UP THE CAUDAL TENDONS AND DOWN TO FOOT. PAINFUL, DEC FLEX/EXTENTION OF THE JOINT. FOOT WNL. CARPUS UP PALP WNL.
PRIOR RADS-NSF.

DDX:SEVERE INFLAMMATION, POSSIBLE JOINT AND TENDON SHEATH INVOLVEMENT.

P:SWEAT WRAP TODAY, O TO REMOVE TOMORROW AND LEAVE BANDAGES OFF JUST HYDRO. PUT OUT IN SMALL PADDOCK TO MOVE AROUND. START BACK ON BUTE.
CALL IF NOT IMPROVING.

B:Billing, C:Med note, CB:Call back, CK:Check-in, CM:Communications, D:Diagnosis, DH:Declined to history, E:Examination, ES:Estimates, I:Departing instr, L:Lab result, M:Image cases, P:Prescription, PA:PVL Accepted, PB:problems, PP:PVL Performed, PR:PVL Recommended, R:Correspondence, T:Images, TC:Tentative medl note, V:Vital signs

Pustejovsky
EXHIBIT NO. 11
2-29-16
Julie A. Jordan

Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Breed: Quarter Horse, American
Age: 12 Yrs. 8 Mos.
Sex: Gelding
Color: Cream/Palomino

Date	Type	Staff	History

12/2-O CALLED, HE IS NOT GETTING BETTER. THE SWELLING IMPROVED WITH SWEAT WRAP BUT HE WAS STILL LAME AND SWELLING CAME BACK BY THE NEXT DAY. STILL LAME AND BUTE NOT HELPING. RECOMMEND REFERRAL TO ORTHO AT TAMU FOR CONSULTATION, POSSIBLE U/S TENDONS AND FURTHER WORK UP AND TX.

11/29/2013	I	LP	REMOVE SWEAT WRAP TOMORROW, THEN NO MORE BANDAGING JUST HYDROTHERAPY. YOU CAN LET HIM OUT INTO A SMALL PADDOCK TO GET HIM MOVING AROUND. GIVE BUTE AS NEEDED. PLEASE CALL IF HE DOES NOT IMPROVE WITH TREATMENT.
11/29/2013	P	LP	40.00 tablet of PHENYLBUTAZONE 1GR. TAB (BUTE1GR) Rx #: 10826 Exp. 11/01/14 0 Of 0 Refills Filled by: LP GIVE 2 GRAMS (2 TABLETS) BY MOUTH TWICE DAILY FOR FIRST DAY. THEN, 1 GRAM TWICE DAILY AS NEEDED FOR PAIN AND INFLAMMATION.
11/29/2013	CK	LP	RE CHECK ON RIGHT FRONT HOOF Reason for Visit: Medical Exam Date Patient Checked Out: 11/29/13 Practice 1
11/29/2013	B	LP	1.00 ZEXAM/EQUINE BRIEF (Z4E1) by BVH
11/29/2013	B	LP	1.00 BANDAGE/SWEAT (4BO) by BVH
11/29/2013	B	LP	40.00 tablet of PHENYLBUTAZONE 1GR. TAB (BUTE1GR) by BVH
11/29/2013	B	LP	1.00 THANK YOU! DR. PUSTEJOVSKY (LP) by BVH
11/26/2013	P	DW	1.00 cc of BANAMINE/FLUNIXIN INJ (BY ML) (BANA) Rx #: 10694 0 Of 0 Refills Filled by: LI GIVE 10CC ONCE A DAY FOR PAIN AND INFLAMMATION
11/26/2013	B	DW	100.00 cc of BANAMINE/FLUNIXIN 50MGML (BANA) by BVH
11/18/2013	B	LA	1.00 tube of PHENYLBUTAZONE PASTE 60ML (11947) by BVH

11/8/2013 C SM RECHECK EXAM - FINAL ***ADDENDUM 12/3/2013
HX: PT WAS DOING WELL BUT NOW RIGHT FRONT FETLOCK IS SWOLLEN & PAINFUL AGAIN

PE: RIGHT FRONT FETLOCK SWOLLEN & WARM TO THE TOUCH, NO SIGNIFICANT LAMENESS OBSERVED, NO DRAINAGE/DISCHARGE, SCAR FROM WOUND IS CLOSED & HEALING WELL; T:99.5

RADIOGRAPHS:

PLAN: CONTINUE REST & HYDRO; USE BUTE A FEW MORE DAYS AS NEEDED FOR PAIN & INFLAMMATION; ANOTHER COURSE OF ANTIBIOTICS SENT HOME AS WELL
ADDENDUM on 12/3/2013 at 11:20:15 from Stefanie Mosley, DVM

B:Billing, C:Med note, CB:Call back, CK:Check-in, CM:Communications, D:Diagnosis, DH:Declined to history, E:Examination, ES:Estimates, I:Departing instr, L:Lab result, M:Image cases, P:Prescription, PA:PVL Accepted, PB:problems, PP:PVL Performed, PR:PVL Recommended, R:Correspondence, T:Images, TC:Tentative medi note, V:Vital signs

Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Age: 12 Yrs. 8 Mos.
Color: Cream/Palomino

Breed: Quarter Horse, American
Sex: Gelding

Date	Type	Staff	History
			RADIOGRAPHS: LATERAL & DP VIEW OF RIGHT FETLOCK REVEALED SIGNIFICANT SOFT TISSUE SWELLING, MILD OSTEOPHYTE PRODUCTION (MOSTLY LATERAL ASPECT), & NARROWED JOINT SPACE; OSSIFICATION OF COLLATERAL CARTILAGE OF P3 IS ALSO OBSERVED
11/8/2013	I	SM	GIVE 1 SCOOP OF BUTE POWDER TWICE DAILY FOR 5-7 DAYS AS NEEDED FOR PAIN & INFLAMMATION.
11/8/2013	P	SM	140.00 tablet of SMZ-TMP 960 (SMZ) Rx #: 9924 Exp. 05/01/16 0 Of 0 Refills Filled by: SM CRUSH TEN TABLETS AND MIX W/ KARO SYRUP AND PLACE IN THE FEED TWICE DAILY UNTIL GONE FOR INFECTION. STOP IF DIARRHEA STARTS.
11/8/2013	CK	SA	SWELLING AND PAIN, CHECKED IN BY SHARON Reason for Visit: Medical Exam Date Patient Checked Out: 11/08/13 Practice 1
11/8/2013	B	SM	EXAM/EQUINE BRIEF (4E1) by BVH
11/8/2013	B	SM	1.00 ZEXAM/EQUINE BRIEF (Z4E1) by BVH
11/8/2013	B	SM	2.00 X-RAY EQUINE/PER VIEW (4XR1) by BVH
11/8/2013	B	SM	140.00 tablet of SMZ-TMP 960 (SMZ) by BVH
11/8/2013	B	SM	1.00 COMMENT (COMI) by BVH
11/8/2013	B	SM	1.00 THANK YOU! DR. MOSLEY (SM) by BVH
10/17/2013	P	JS	140.00 tablet of SMZ-TMP 960 (SMZ) Rx #: 8995 Exp. 05/01/16 0 Of 0 Refills Filled by: JS CRUSH TEN TABLETS AND MIX W/ KARO SYRUP AND PLACE IN THE FEED ONCE DAILY UNTIL GONE FOR INFECTION. STOP IF DIARRHEA STARTS
10/17/2013	P	JS	140.00 tablet of SMZ-TMP 960 (SMZ) Rx #: 8994 Exp. 05/01/16 0 Of 0 Refills Filled by: JS GIVE TEN TABLETS IN THE FEED ONCE DAILY UNTIL GONE FOR INFECTION.
10/17/2013	B	JS	140.00 tablet of SMZ-TMP 960 (SMZ) by BVH
10/14/2013	P	JS	80.00 tablet of SMZ-TMP 960 (SMZ) Rx #: 8843 0 Of 0 Refills Filled by: MC GIVE 10 TABLETS BY MOUTH (MIX WITH FEED) TWICE DAILY UNTIL GONE FOR INFECTION.
10/14/2013	CK	LA	O IN LOBBY REQ: MEDS FOR THIS HORSE/O REPPORTS CUT ON RIGHT FRONT ANKLE CHECKED IN BY MARCIE Reason for Visit: Not Available Date Patient Checked Out: 10/14/13 Practice 1

B:Billing, C:Med note, CB:Call back, CK:Check-in, CM:Communications, D:Diagnosis, DH:Declined to history, E:Examination, ES:Estimates, I:Departing Instr, L:Lab result, M:Image cases, P:Prescription, PA:PVL Accepted, PB:problems, PP:PVL Performed, PR:PVL Recommended, R:Correspondence, T:Images, TC:Tentative medi note, V:Vital signs

Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Age: 12 Yrs. 8 Mos.
Color: Cream/Palomino

Breed: Quarter Horse, American
Sex: Gelding

Date	Type	Staff	History
10/14/2013	B	JS	80.00 tablet of SMZ-TMP 960 (SMZ) by BVH
10/14/2013	B	JS	2.00 each of COMBINE ROLL (COMROL) by BVH
10/5/2013	I	HM	PLEASE CONTINUE WRAPPING THE WOUND ONCE A DAY. SWITCH OINTMENTS THAT ARE APPLIED TO THE WOUND EVERY DAY SWITCHING FROM GRANULEX TO QUADRATOP.,
10/5/2013	B	HM	.50 bottle of QUADRITOP OINTMENT (006572) by CR
10/5/2013	B	HM	1.00 COMMENT (COMI) by CR
10/5/2013	B	HM	1.00 THANK YOU! DR. MOORE (HM) by CR

9/28/2013 C SM RECHECK WOUND - FINAL 09/28/2013

HX: O HAS BEEN DOING HYDRO THERAPY ON WOUND & CHANGING BANDAGE DAILY; O IS STILL GIVING ORAL ANTIBIOTIC BUT HAS STOPPED GIVING BANAMINE

PE: NO SIGNIFICANT LAMENESS OBSERVED; A FEW SUTURES HAVE COME OUT & EDGES OF LACERATION HAS NOT HEALED; WOUND IS STILL VERY THICKENED & WILL NOT CLOSE EASILY; MILD HEMORRHAGIC/PURULENT DISCHARGE OBSERVED; T: 100.3

TX: REMAINING SUTURES REMOVED; WOUND WAS CLEANED & TISSUE WAS DEBRIDED; GRANULEX SPRAY & A TIGHT BANDAGE WAS APPLIED

PLAN: MORE SMZ TABS WERE SENT HOME TO EXTEND TREATMENT; O WILL CONTINUE HYDROTHERAPY & BANDAGE CHANGES WITH GRANULEX DAILY

9/28/2013	P	SM	80.00 tablet of SMZ-TMP 960 (SMZ) Rx #: 8262 0 Of 0 Refills Filled by: SM GIVE 10 TABLETS BY MOUTH (MIX IN FEED) TWICE DAILY UNTIL GONE FOR INFECTION.
9/28/2013	CK	SM	RECHECK- SUTURES COMING OPEN Reason for Visit: Recheck Date Patient Checked Out: 09/28/13 Practice 1
9/28/2013	B	SM	EXAM/EQUINE BRIEF (4E1) by BVH
9/28/2013	B	SM	1.00 ZEXAM/EQUINE BRIEF (Z4E1) by BVH
9/28/2013	B	SM	.50 BANDAGE LEG/COMBINE ROLL (4B1) by BVH
9/28/2013	B	SM	1.00 each of GRANULEX V SPRAY (8252) by BVH
9/28/2013	B	SM	2.00 each of CAST PADDING 4 (CP4) by BVH
9/28/2013	B	SM	80.00 tablet of SMZ-TMP 960 (SMZ) by BVH
9/28/2013	B	SM	1.00 THANK YOU! DR. MOSLEY (SM) by BVH

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Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Age: 12 Yrs. 8 Mos.
Color: Cream/Palomino

Breed: Quarter Horse, American
Sex: Gelding

Date	Type	Staff	History
9/25/2013	P	DW	100.00 cc of BANAMINE/FLUNIXIN INJ (BY ML) (BANA) Rx #: 8134 0 Of 0 Refills Filled by: DW GIVE 10 CC IN THE MUSCLE OR VEIN ONCE DAILY AS NEEDED FOR PAIN AND INFLAMMATION
9/25/2013	B	DW	100.00 cc of BANAMINE/FLUNIXIN 50MGML (BANA) by CR
9/21/2013	P	SM	1.00 [None] of TETANUS TOXOID (4TT) Rx #: 7981 0 Of 0 Refills Filled by: SM GIVE FULL SYRINGE (1CC) IN THE NECK MUSCLE ONCE FOR TETANUS VACCINATION.
9/21/2013	B	SM	1.00 TETANUS TOXOID (4TT) by CR
9/21/2013	B	SM	1.00 THANK YOU! DR. MOSLEY (SM) by CR
9/20/2013	I	SM	PLEASE REMOVE SUTURES IN 7-10 DAYS!
9/20/2013	P	SM	200.00 tablet of SMZ-TMP 960 (SMZ) Rx #: 7970 0 Of 0 Refills Filled by: TR GIVE 10 TABLETS BY MOUTH (MIX IN FEED) TWICE DAILY UNTIL GONE FOR INFECTION.

9/20/2013 C SM ENTER DOCTOR ID - Manner of Administration Document - FINAL 09/23/2013

MEDICATION	Manner of Administration			
Acepromazine Injection 10 mg/ml	☐ SQ	☐ IV	☐ IM	☐ PO
Antisedan 0.5 mg/ml	☐ SQ	☐ IV	☐ IM	☐ PO
Atropine injection SA	☐ SQ	☐ IV	☐ IM	☐ PO
Banamine/Flunixin 50mg/ml	☐ SQ	☐ IV	☐ IM	☐ PO
Baytril inj 100 mg/ml	☐ SQ	☐ IV	☐ IM	☐ PO
Baytril Injection 22.7mg	☐ SQ	☐ IV	☐ IM	☐ PO
Benadyrl injection 50mg	☐ SQ	☐ IV	☐ IM	☐ PO
Cefazolin Sodium 1 gm	☐ SQ	☐ IV	☐ IM	☐ PO
Cerenia Injection	☐ SQ	☐ IV	☐ IM	☐ PO
Convenia injection	☐ SQ	☐ IV	☐ IM	☐ PO
Depo Medrol 20 mg/ml	☐ SQ	☐ IV	☐ IM	☐ PO
Dexamethasone 2 mg/ml	☐ SQ	☐ IV	☐ IM	☐ PO
Dexdomitor 0.5 mg/ml	☐ SQ	☐ IV	☐ IM	☐ PO
Dipyrone injection 500mg/ml	☐ SQ	☐ IV	☐ IM	☐ PO
Dolorex 10 mg/ml	☐ SQ	☐ IV	☐ IM	☐ PO
Dopram V injection 5mg/ml	☐ SQ	☐ IV	☐ IM	☐ PO
Dormosedan 10 mg/ml	☐ SQ	☒ IV	☐ IM	☐ PO
Draxxin 100 mg/ml	☐ SQ	☐ IV	☐ IM	☐ PO

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Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Age: 12 Yrs. 8 Mos.
Color: Cream/Palomino

Breed: Quarter Horse, American
Sex: Gelding

Date	Type	Staff	History

Epinephrine		☐ SQ	☐ IV	☐ IM	☐ PO
Furosemide injection 50mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Gentocin 100mg/250 cc		☐ SQ	☐ IV	☐ IM	☐ PO
Glycopyrrolate 0.2mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Ketamine 100 mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Metacam/Loxicom injection 5mg		☐ SQ	☐ IV	☐ IM	☐ PO
Metoclopramide inj /5MGML		☐ SQ	☐ IV	☐ IM	☐ PO
Midazolam 5 mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Naxcel 1gm 20 ml		☐ SQ	☐ IV	☐ IM	☐ PO
Nuflor 100 ml 300 mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Oxybiotic 200mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Oxytocin injection		☐ SQ	☐ IV	☐ IM	☐ PO
Penicillin G		☐ SQ	☐ IV	☐ IM	☐ PO
Phenylbutazone inj 20%		☐ SQ	☐ IV	☐ IM	☐ PO
Potassium injection		☐ SQ	☐ IV	☐ IM	☐ PO
Predef 2x in 2 MG/ML		☐ SQ	☐ IV	☐ IM	☐ PO
Solu-Delta Cortef 100 mg		☐ SQ	☐ IV	☐ IM	☐ PO
Sucostrin inj 20 MG/ML		☐ SQ	☐ IV	☐ IM	☐ PO
Tetanus Toxoid		☐ SQ	☐ IV	☐ IM	☐ PO
Telazol 100 mg 5 ml		☐ SQ	☐ IV	☐ IM	☐ PO
Valium injection 5 MG		☐ SQ	☐ IV	☐ IM	☐ PO
Vetalog inj 2 MG/ML		☐ SQ	☐ IV	☐ IM	☐ PO
VIT. A/D/E Injection		☐ SQ	☐ IV	☐ IM	☐ PO
VIT. B12 - 3000		☐ SQ	☐ IV	☐ IM	☐ PO
VIT. B Complex		☐ SQ	☐ IV	☐ IM	☐ PO
VIT. C Inj 250 ML		☐ SQ	☐ IV	☐ IM	☐ PO
VIT. K Inj		☐ SQ	☐ IV	☐ IM	☐ PO
Xylazine		☐ SQ	☐ IV	☐ IM	☐ PO

9/20/2013	CK	SM	O THINKS P HAS BEEN ATTACKED BY NEIGHBOR Date Patient Checked Out: 09/20/13 Practice 1

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Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Breed: Quarter Horse, American
Age: 12 Yrs. 8 Mos.
Sex: Gelding
Color: Cream/Palomino

Date	Type	Staff	History

9/20/2013 C SM EXAM - WOUND - FINAL 09/24/2013

HX: O JUST NOTICED WOUND ON LEG; O REPORTS PT WAS NOT WALKING WELL UNTIL AFTER 10CC BANAMINE GIVEN AT HOME

PE: BAR; ORAL- PINK & MOIST MM; H/L- WNL; GI- WNL IN ALL QUADRANTS; ORTHO- GRADE 2 LAMENESS ON RIGHT FORELIMB; SKIN/MS- UPSIDE DOWN V-SHAPED LACERATION ON LATERAL ASPECT OF RIGHT FRONT FETLOCK, MOD SQ DAMAGE & MOD SWELLING OBSERVED; T: 100.8

TX: PT SEDATED TO SUTURE WOUND CLOSE - WOUND CLOSED EASILY ON CAUDAL ASPECT BUT CRANIAL ASPECT WAS VERY TIGHT & DID NOT CLOSE COMPLETELY; BANDAGE WAS APPLIED TO HELP KEEP WOUND CLOSED & COVERED

PLAN: SENT HOME SMZ TABS & O HAS BANAMINE TO CONTINUE AS NEEDED; O WILL CHANGE BANDAGE & HYDRO WOUND ONCE DAILY; O WAS WARNED THAT SUTURES MAY BUST OUT BUT ADVISED TO KEEP IT BANDAGED UNTIL IT HEALS OR SCABS OVER

9/20/2013	B	SM	EMERGENCY SERVICE (4EXEME) by BVH
9/20/2013	B	SM	1.00 ZEMERGENCY SERVICE (Z4EXEME) by BVH
9/20/2013	B	SM	1.00 ER TECH FEE - TR (1MCM) by BVH
9/20/2013	B	SM	EXAM/EQUINE DOCTOR CONSULT (4EXR) by BVH
9/20/2013	B	SM	1.00 ZEXAM/EQUINE DOCTOR CONSULT (Z4EXR) by BVH
9/20/2013	B	SM	.50 cc of DORMOSEDAN 10MG/ML. (DORM) by BVH
9/20/2013	B	SM	SUTURE WOUND/MINIMUM (4SW1) by BVH
9/20/2013	B	SM	1.00 ZSUTURE WOUND/MINIMUM (Z4SW1) by BVH
9/20/2013	B	SM	SURICAL PREP/PACK (STEL) by BVH
9/20/2013	B	SM	1.00 ZSURICAL PREP/PACK (ZSTEL) by BVH
9/20/2013	B	SM	1.00 each of VICRYL #2/0 W/CP1 (VICR) by BVH
9/20/2013	B	SM	1.00 each of BRAUNAMID #3 (JOR3409) by BVH
9/20/2013	B	SM	1.00 BANDAGE/FOOT W/OINT. (4B3) by BVH
9/20/2013	B	SM	200.00 tablet of SMZ-TMP 960 (SMZ) by BVH
9/20/2013	B	SM	1.00 COMMENT (COMI) by BVH
9/20/2013	B	SM	1.00 THANK YOU! DR. MOSLEY (SM) by BVH
8/16/2013	B	JS	1.00 each of GRANULEX V SPRAY (8252) by CR
7/22/2013	P	LP	1.00 [None] of TETANUS TOXOID (4TT) Rx #: 5305 Exp. 07/24/14 0 Of 0 Refills Filled by: ZB GIVE 1CC IN NECK MUSCLE ONCE FOR VACCINATION.

B:Billing, C:Med note, CB:Call back, CK:Check-in, CM:Communications, D:Diagnosis, DH:Declined to history, E:Examination, ES:Estimates, I:Departing instr, L:Lab result, M:Image cases, P:Prescription, PA:PVL Accepted, PB:problems, PP:PVL Performed, PR:PVL Recommended, R:Correspondence, T:Images, TC:Tentative medl note, V:Vital signs

Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Age: 12 Yrs. 8 Mos.
Color: Cream/Palomino

Breed: Quarter Horse, American
Sex: Gelding

Date	Type	Staff	History
7/22/2013	B	LP	1.00 TETANUS TOXOID (4TT) by BVH

7/20/2013 C LP EXAM NOTES - FINAL 07/20/2013

HX:HE WENT OUT CUT BACK LIMBS WHEN GOT STUCK IN BARB WIRE FENCE FIGHTING WITH NEIGHBORS HORSES. HAPPENED RECENTLY WAS FINE THIS MORNING. O UNABLE TO GIVE INJECTABLE MEDICATIONS.

PE:T100.2. BAR. MM-PL/PK. MILD INC IN SKIN TENT. EYES WNL. BCS 6/9. H/L-WNL, CLEAR P40. GUT SOUNDS WNL. SKIN-SMALL SUPERFICIAL CUT ON THE LEFT SHOULDER. BOTH BACK LIMBS, MULTIPLE SUPERIFICAL CUTS OVER THE CRANIAL ASPECT OF HOCK AND DISTAL TO IT. LEFT WORSE, DOWN DISTALLY LARGER SUPERFICAL OPEN WOUND MISSING PATCH OF SKIN. MILD SWELLING ON THE MEDIAL ASPECTS, TENDONS WNL. AMBULATING ON ALL 4S, MILDLY PAINFUL. DDX:OPEN LACERATIONS-TO HEAL BY SECOND INTENTION, INFECTION.

P:HYDRO, SCRUBBED WOUNDS WITH CHLORHEX. O TO BANADAGE AND KEEP CLEAN.
SMZ AND BUTE-START TOMORROW AT HOME. KEEP UP RESTED.

7/20/2013	I	LP	RECOMMEND HYDROPTHERAPY ATLEAST ONCE DAILY FOR 10 MINUTES, KEEP WOUND CLEAN AND DRY. YOU CAN BANDAGE HIND LEGS AS NEEDED. PLEASE CALL IF THE WOUNDS START DRAINING OR HAVE INFECTED DISCHARGE. RECOMMEND KEEPING HIM UP FOR A COUPLE WEEKS.
7/20/2013	P	LP	40.00 tablet of PHENYLBUTAZONE 1GR. TAB (BUTE1GR) Rx #: 5275 Exp. 07/01/14 0 Of 0 Refills Filled by: LP GIVE 1 GRAM (TABLET) BY MOUTH TWICE DAILY AS NEEDED FOR PAIN AND INFLAMMATION. *START TOMORROW.
7/20/2013	P	LP	140.00 tablet of SMZ-TMP 960 (SMZ) Rx #: 5274 Exp. 07/01/14 0 Of 0 Refills Filled by: LP GIVE 10 TABLETS BY MOUTH TWICE DAILY UNTIL GONE FOR INFECTION. *CAN MIX INTO FEED OR DISSOLVE IN SYRINGE*

7/20/2013 C LP ENTER DOCTOR ID - Manner of Administration Document - FINAL 07/20/2013

MEDICATION	Manner of Administration			
Acepromazine Injection 10 mg/ml	☐ SQ	☐ IV	☐ IM	☐ PO
Antisedan 0.5 mg/ml	☐ SQ	☐ IV	☐ IM	☐ PO

B:Billing, C:Med note, CB:Call back, CK:Check-in, CM:Communications, D:Diagnosis, DH:Declined to history, E:Examination, ES:Estimates, I:Departing instr, L:Lab result, M:Image cases, P:Prescription, PA:PVL Accepted, PB:problems, PP:PVL Performed, PR:PVL Recommended, R:Correspondence, T:Images, TC:Tentative medl note, V:Vital signs

Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Age: 12 Yrs. 8 Mos.
Color: Cream/Palomino

Breed: Quarter Horse, American
Sex: Gelding

Date	Type	Staff	History

Atropine injection SA		☐ SQ	☐ IV	☐ IM	☐ PO
Banamine/Flunixin 50mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Baytril inj 100 mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Baytril Injection 22.7mg		☐ SQ	☐ IV	☐ IM	☐ PO
Benadyrl injection 50mg		☐ SQ	☐ IV	☐ IM	☐ PO
Cefazolin Sodium 1 gm		☐ SQ	☐ IV	☐ IM	☐ PO
Cerenia Injection		☐ SQ	☐ IV	☐ IM	☐ PO
Convenia injection		☐ SQ	☐ IV	☐ IM	☐ PO
Depo Medrol 20 mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Dexamethasone 2 mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Dexdomitor 0.5 mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Dipyrone injection 500mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Dolorex 10 mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Dopram V injection 5mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Dormosedan 10 mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Draxxin 100 mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Epinephrine		☐ SQ	☐ IV	☐ IM	☐ PO
Furosemide injection 50mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Gentocin 100mg/250 cc		☐ SQ	☐ IV	☐ IM	☐ PO
Glycopyrrolate 0.2mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Ketamine 100 mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Metacam/Loxicom injection 5mg		☐ SQ	☐ IV	☐ IM	☐ PO
Metoclopramide inj /5MGML		☐ SQ	☐ IV	☐ IM	☐ PO
Midazolam 5 mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Naxcel 1gm 20 ml		☐ SQ	☐ IV	☐ IM	☐ PO
Nuflor 100 ml 300 mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Oxybiotic 200mg/ml		☐ SQ	☐ IV	☐ IM	☐ PO
Oxytocin injection		☐ SQ	☐ IV	☐ IM	☐ PO
Penicillin G		☐ SQ	☐ IV	☐ IM	☐ PO
Phenylbutazone inj 20%		☐ SQ	☒ IV	☐ IM	☐ PO
Potassium injection		☐ SQ	☐ IV	☐ IM	☐ PO
Predef 2x in 2 MG/ML		☐ SQ	☐ IV	☐ IM	☐ PO
Solu-Delta Cortef 100 mg		☐ SQ	☐ IV	☐ IM	☐ PO
Sucostrin inj 20 MG/ML		☐ SQ	☐ IV	☐ IM	☐ PO
Tetanus Toxoid		☐ SQ	☐ IV	☐ IM	☐ PO
Telazol 100 mg 5 ml		☐ SQ	☐ IV	☐ IM	☐ PO

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Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Age: 12 Yrs. 8 Mos.
Color: Cream/Palomino

Breed: Quarter Horse, American
Sex: Gelding

Date	Type	Staff	History

Valium injection 5 MG		☐ SQ	☐ IV	☐ IM	☐ PO
Vetalog inj 2 MG/ML		☐ SQ	☐ IV	☐ IM	☐ PO
VIT. A/D/E Injection		☐ SQ	☐ IV	☐ IM	☐ PO
VIT. B12 - 3000		☐ SQ	☐ IV	☐ IM	☐ PO
VIT. B Complex		☐ SQ	☐ IV	☐ IM	☐ PO
VIT. C Inj 250 ML		☐ SQ	☐ IV	☐ IM	☐ PO
VIT. K Inj		☐ SQ	☐ IV	☐ IM	☐ PO
Xylazine		☐ SQ	☐ IV	☐ IM	☐ PO

7/20/2013	B	LP	EMERGENCY SERVICE (4EXEME) by BVH
7/20/2013	B	LP	1.00 ZEMERGENCY SERVICE (Z4EXEME) by BVH
7/20/2013	B	LP	1.00 ZEXAM/EQUINE DOCTOR CONSULT (Z4EXR) by BVH
7/20/2013	B	LP	10.00 cc of PHENYLBUTAZONE INJ 20% (BI) by BVH
7/20/2013	B	LP	140.00 tablet of SMZ-TMP 960 (SMZ) by BVH
7/20/2013	B	LP	40.00 tablet of PHENYLBUTAZONE 1GR. TAB (BUTE1GR) by BVH
7/20/2013	B	LP	1.00 THANK YOU! DR. PUSTEJOVSKY (LP) by BVH
4/20/2013	P	LA	0.80 [None] of RABIES - EQUINE (4RV) Rx #: 814 0 Of 0 Refills Filled by: TR GIVE 1 SYRINGE (2CC) IN THE MUSCLE.
4/20/2013	B	LA	.80 RABIES - EQUINE (4RV) by MV
3/16/2013	B	SA	1.00 VEWT (4VEWT) by CS
3/16/2013	B	SA	1.00 WEST NILE VACCINE (4WV) by CS
7/24/2012	B	DW	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
7/24/2012	C	DW	EXAM-O SAYS HAS SPOT ON LEFT HIP WANTS LOOKED AT
7/24/2012	B	DW	1.00 APPOINTMENT (AP) by CS
7/24/2012	B	DW	1.00 ADMITTING BY CHELSEA (ACG) by CS
7/24/2012	B	DW	1.00 TIME STAMP 2:51pm (T) by CS
7/24/2012	B	DW	1.00 EXAM/EQUINE DOCTOR CONSULT (Z4EXR) by CS
7/24/2012	B	DW	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
7/24/2012	C	DW	PREVIOUS AREAS WHERE OWNER ASSUMED WAS BURNED ON RIGHT HIP

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Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Breed: Quarter Horse, American
Age: 12 Yrs. 8 Mos.
Sex: Gelding
Color: Cream/Palomino

Date	Type	Staff	History
7/24/2012	C	DW	LOOKS MUCH IMPROVED AND 90% HEALED
7/24/2012	C	DW	2-3 CM RAISED SKIN CALLOUS TYPE AREA ON LR LATERAL STIFLE
7/24/2012	C	DW	NOT SURE CAUSE, BUT APPEARS TO BE JUST SKIN THICKENING AND
7/24/2012	C	DW	EXPLAINED TO OWNER WILL LIKELY NOT GO AWAY
7/24/2012	C	DW	NO TREATMENT APPEARS TO BE NEEDED AT THIS TIME
7/24/2012	B	DW	1.00 THANK YOU! DR. WEISS (DW) by CS
7/24/2012	B	DW	1.00 DISCHARGE BY CHELSEA (DCG) by CS
7/24/2012	B	DW	1.00 TIME STAMP 3:07pm (T) by CS
7/12/2012	B	DW	14.00 ounce of RX:___SSD CREAM 400 GM/16OZ (SSDCRE) by CS
7/12/2012	C	DW	#00232840 EXP.: 12/20/13
7/12/2012	C	DW	APPLY TOPICALLY TO AREA ON HIP
7/12/2012	C	DW	DAILY UNTIL HEALED
7/12/2012	B	DW	1.00 DISCHARGE BY CHELSEA (DCG) by CS
7/12/2012	B	DW	1.00 TIME STAMP 5:19pm (T) by CS
4/28/2012	B	HM	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
4/28/2012	C	HM	O REPORT A SWOLLEN SHEATH

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Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Age: 12 Yrs. 8 Mos.
Color: Cream/Palomino

Breed: Quarter Horse, American
Sex: Gelding

Date	Type	Staff	History
4/28/2012	B	HM	1.00 APPOINTMENT (AP) by CS
4/28/2012	B	HM	1.00 TIME STAMP 9:01am (T) by CS
4/28/2012	B	HM	1.00 ADMITTING BY MARCIE (AMS) by CS
4/28/2012	B	HM	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
4/28/2012	C	HM	O REQ: CT - O TO P/U RESULTS, PLEASE CALL 480-5670
4/28/2012	B	HM	1.00 APPOINTMENT (AP) by CS
4/28/2012	B	HM	1.00 TIME STAMP 9:02am (T) by CS
4/28/2012	B	HM	1.00 ADMITTING BY MARCIE (AMS) by CS
4/28/2012	B	HM	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
4/28/2012	C	HM	O REQ: FECAL - IN LAB
4/28/2012	B	HM	1.00 FECAL EXAM EQUINE (4FE) by CS
4/28/2012	C	HM	FECAL WAS NEGATIVE FOR INTESTINAL PARASITES.
4/28/2012	B	HM	1.00 EXAM/EQUINE BRIEF (Z4E1) by CS
4/28/2012	B	HM	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
4/28/2012	C	HM	VENTRAL ASPECT OF SHEATH IS SWOLLEN. BEANS IN PENIS ARE
4/28/2012	C	HM	SOFT AND EASILY REMOVED. REMAINING SHEATH IS DIRTY.
4/28/2012	C	HM	EATING AND DRINKING WELL.

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Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Age: 12 Yrs. 8 Mos.
Color: Cream/Palomino

Breed: Quarter Horse, American
Sex: Gelding

Date	Type	Staff	History
4/28/2012	B	HM	1.00 SHEATH CLEANING EQUINE (Z4S) by CS
4/28/2012	B	HM	1.50 cc of IV:___ACEPROMAZINE INJ 10MG/ (ACEINJ) by CS
4/28/2012	B	HM	1.00 cc of IV:___XYLAZINE 100 MG/ML (X) by CS
4/28/2012	B	HM	1.00 DIGITAL COGGINS TEST (4DCT) by CS
4/28/2012	B	HM	1.00 THANK YOU! DR. MOORE (HM) by CS
4/28/2012	C	HM	PLEASE APPLY HYDROTHERAPY AND GIVE BANAMINE AS NEEDED FOR
4/28/2012	C	HM	SWELLING UP TO 5 DAYS.
4/28/2012	B	HM	100.00 cc of RX:___BANAMINE/FLUNIXIN 50MG (BANA) by CS
4/28/2012	C	HM	#00228224 EXP.: 11/01/13
4/28/2012	C	HM	GIVE 10CC IN THE MUSCLE OF THE NECK
4/28/2012	C	HM	OR INTRAVENOUSLY ONCE A DAY FOR PAIN
4/28/2012	C	HM	AND INFLAMMATION OR FOR EMERGENCY
4/28/2012	C	HM	COLIC.
4/28/2012	B	HM	10.00 cc of IV:___BANAMINE/FLUNIXIN 50MG (BANA) by CS
4/28/2012	B	HM	1.00 THANK YOU! DR. MOORE (HM) by CS
2/18/2012	B	LA	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
2/18/2012	C	LA	O REQ RV TO GO HOME

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Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Breed: Quarter Horse, American
Age: 12 Yrs. 8 Mos.
Sex: Gelding
Color: Cream/Palomino

Date	Type	Staff	History
2/18/2012	B	LA	1.00 WALK IN (WI) by CS
2/18/2012	B	LA	1.00 TIME STAMP 11:07am (T) by CS
2/18/2012	B	LA	1.00 ADMITTING BY CHELSEA (ACG) by CS
2/18/2012	B	HM	.24 dose of RX:___RABIES VACCINATION 3YR (4997) by CS
2/18/2012	C	HM	#00223842 EXP.: 0/00/00
2/18/2012	C	HM	GIVE IN THE MUSCLE OF THE NECK
2/18/2012	C	HM	ONCE FOR RABIES VACCINATION.
2/18/2012	B	HM	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
2/18/2012	C	HM	2 RABIES SENT HOME FOR RACHEL AND HARVEY
1/28/2012	B	SA	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
1/28/2012	C	SA	WEST NILE TO GO HOME
1/28/2012	B	SA	1.00 TIME STAMP 11:42am (T) by CS
1/28/2012	B	LA	1.00 WEST NILE VACCINE (4WV) by CS
1/14/2012	B	LA	1.00 VEWT (4VEWT) by CS
7/13/2011	B	LA	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
7/13/2011	C	LA	DROP OFF

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Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Age: 12 Yrs. 8 Mos.
Color: Cream/Palomino

Breed: Quarter Horse, American
Sex: Gelding

Date	Type	Staff	History
4/25/2011	C	SG	FECAL EXAM NEGATIVE
12/16/2010	B	SG	2.00 ounce of RX:___PANACUR/PER OZ 100 MG/ (PANACUR) by CS
12/16/2010	C	SG	#00201103 EXP.: 4/01/12
12/16/2010	C	SG	GIVE EACH HORSE 25MLS BY MOUTH TODAY AND
12/16/2010	C	SG	50 MLS BY MOUTH ONCE A DAY FOR 4 MORE
12/16/2010	C	SG	DAYS. (GAVE ONE TUBE OF SAFEGUARD TODAY
12/16/2010	B	SG	1.00 THANK YOU! DR. GUYNN (SG) by CS
12/16/2010	B	SG	1.00 DISCHARGE BY SANDRA (DSC) by CS
12/4/2010	B	LA	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
12/4/2010	C	LA	WEST NILE AND RV
12/4/2010	C	LA	O TO TAKE HOME
12/4/2010	B	LA	1.00 WALK IN (WI) by CS
12/4/2010	B	LA	1.00 ADMITTING BY CHELSEA (ACG) by CS
12/4/2010	B	LA	1.00 TIME STAMP 9:10am (T) by CS
12/4/2010	B	CH	1.00 RABIES (4RV) by CS
12/4/2010	B	CH	1.00 WEST NILE VACCINE (4WV) by CS
12/4/2010	B	CH	14.00 ounce of RX:___PANACUR/PER OZ 100 MG/ (PANACUR) by CS

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Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Breed: Quarter Horse, American
Age: 12 Yrs. 8 Mos.
Sex: Gelding
Color: Cream/Palomino

Date	Type	Staff	History
12/4/2010	C	CH	#00200520 EXP.: 10/01/12
12/4/2010	C	CH	GIVE 50CC BY MOUTH ONCE DAILY FOR
12/4/2010	C	CH	5 DAYS FOR DEWORMING
11/8/2010	B	LA	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
11/8/2010	C	LA	SNOTTY NOSE. WHITE/GREENISH DISCHARGE / E/D OKAY THIS AM
11/8/2010	C	LA	NO TEMP TAKEN THIS AM / WAS 100.0 LAST NIGHT AROUND 530
11/8/2010	C	LA	FECES LOOKS OK PER OWNER
11/8/2010	B	LA	1.00 TIME STAMP 7:49am (T) by CS
11/8/2010	B	LA	1.00 ADMITTING BY MAURA (AMR) by CS
11/8/2010	B	LA	1.00 WALK IN (WI) by CS
11/8/2010	B	SG	1.00 EXAM/EQUINE DOCTOR CONSULT (Z4EXR) by CS
11/8/2010	B	SG	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
11/8/2010	C	SG	T-101.7; MM PALE PINK, CRT=2SEC, WOULD LIKE A WEE BIT
11/8/2010	C	SG	MOISTER
11/8/2010	C	SG	LUNGS ASC CLEAR ON BOTH SIDES BUT HORSE IS COUGHING PER THE
11/8/2010	C	SG	OWNER; MILD MUCOPURULENT DISCHARGE ON BOTH SIDES OF THE

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Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Age: 12 Yrs. 8 Mos.
Color: Cream/Palomino

Breed: Quarter Horse, American
Sex: Gelding

Date	Type	Staff	History
8/19/2009	C	SG	2 INCH GASH SKIN THICK ON RIGHT FRONT PEC - COULD'VE NOT
8/19/2009	C	SG	SUTURED BUT O WANTED SUTURED TO KEEP CLEAN
8/19/2009	C	SG	18 OR SO HOURS OLD - SCRAPED EDGES AND GOT DECENT BLOOD
8/19/2009	C	SG	FLOW
8/19/2009	C	SG	PUT IN 5 INTERUPTED SUTURES
8/19/2009	B	SG	1.00 THANK YOU! DR. GUYNN (SG) by CS
8/19/2009	C	SG	KEEP SWAT ON THE WOUND FOR AT LEAST 10-14 DAYS.
8/19/2009	C	SG	SUTURE REMOVAL IN 10-14 DAYS.
8/19/2009	B	SG	1.00 TIME STAMP 9:42am (T) by CS
8/19/2009	B	SG	1.00 DISCHARGE BY MARCIE (DMS) by CS
4/16/2009	B	SG	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
4/16/2009	C	SG	CT
4/16/2009	C	SG	PLEASE MAIL CT RESULTS
4/16/2009	C	SG	CHECK TEETH

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Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Breed: Quarter Horse, American
Age: 12 Yrs. 8 Mos.
Sex: Gelding
Color: Cream/Palomino

Date	Type	Staff	History
4/16/2009	C	SG	ANNUAL VACCS - O SAYS 4 SHOT + RV
4/16/2009	C	SG	SHEATH CLEANING
4/16/2009	B	SG	1.00 APPOINTMENT (AP) by CS
4/16/2009	B	SG	1.00 TIME STAMP 9:57am (T) by CS
4/16/2009	B	SG	1.00 ADMITTING BY MARCIE (AMS) by CS
4/16/2009	B	SG	1.00 FLOAT PNEUMATIC MAINTENCE (Z4DS) by CS
4/16/2009	B	SG	1.00 cc of IV:___XYLAZINE 100 MG/ML (X) by CS
4/16/2009	B	SG	.50 cc of RX:___DORMOSEDAN 10MG/ML. (DORM) by CS
4/16/2009	B	SG	1.00 EQUINE ANNUAL VACCINATIONS (Z4ANN) by CS
4/16/2009	B	SG	1.00 VEWT (4VEWT) by CS
4/16/2009	B	SG	1.00 RABIES (4RV) by CS
4/16/2009	B	SG	1.00 FLU-RHINO (4FR) by CS
4/16/2009	B	SG	1.00 STREP/STRANGLES (4STR) by CS
4/16/2009	B	SG	1.00 PREVENILE VACCINE (4WV) by CS
4/16/2009	B	SG	1.00 DIGITAL COGGINS TEST (4DCT) by CS
4/16/2009	B	SG	1.00 SHEATH CLEANING EQUINE (Z4S) by CS
4/16/2009	B	SG	1.00 cc of IV:___ACEPROMAZINE INJ 10MG/ (ACEINJ) by CS
4/16/2009	B	SG	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
4/16/2009	C	SG	1ST ON CAMERA - HM IN CIRCLE ON LEFT HIP
4/16/2009	C	SG	RIGHT HIND SOCK AND BLAZE
9/25/2008	B	SG	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
9/25/2008	C	SG	HAS A DISCHARGE FROM LEFT EYE
9/25/2008	B	SG	1.00 TIME STAMP 4:30pm (T) by CS
9/25/2008	B	SG	1.00 APPOINTMENT (AP) by CS

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Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Breed: Quarter Horse, American
Age: 12 Yrs. 8 Mos.
Sex: Gelding
Color: Cream/Palomino

Date	Type	Staff	History
9/25/2008	B	SG	1.00 ADMITTING BY LISA (CONVLN) by CS
9/25/2008	B	SG	1.00 EXAM/EQUINE DOCTOR CONSULT (Z4EXR) by CS
9/25/2008	B	SG	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
9/25/2008	C	SG	EYE DISCHARGE FROM THE LEFT EYE; PUPIL WIDE AND OPEN - LOTS
9/25/2008	C	SG	OF PURULENT DISCHARGE AND DEBRIS/DIRT IN THE CORNER OF THE
9/25/2008	C	SG	EYE - NASOLACRIMAL DUCT LOOKS RED AND A LITTLE SWOLLEN -
9/25/2008	C	SG	FLUSHED IT AND A LONG SKINNY BOOGER CAME OUT INTO EYE -
9/25/2008	C	SG	EASILY FLUSHED 35CC SALINE AFTER THAT - DDX BLOCKED TEAR
9/25/2008	C	SG	DUCT
9/25/2008	B	SG	1.00 FLUSH/NASO-LAC DUCT (4FD) by CS
9/25/2008	B	SG	1.00 each of RX:___NEOBACYMIX-H OPHTH. OI (NEOB) by CS
9/25/2008	C	SG	#00157585 EXP.: 10/01/10
9/25/2008	C	SG	PUT ONE INCH IN LEFT EYE 2X A DAY FOR A
9/25/2008	C	SG	WEEK TO DECREASE ANY SWELLING IN THE
9/25/2008	C	SG	NASOLACRIMAL DUCT.

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Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Breed: Quarter Horse, American
Age: 12 Yrs. 8 Mos.
Sex: Gelding
Color: Cream/Palomino

Date	Type	Staff	History
9/25/2008	B	SG	1.00 THANK YOU! DR. GUYNN (SG) by CS
9/25/2008	B	SG	1.00 TIME STAMP 4:56pm (T) by CS
9/25/2008	B	SG	1.00 DISCHARGE BY LISA (CONVLN) by CS
4/8/2008	B	SG	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
4/8/2008	C	SG	ANNUAL VACCS
4/8/2008	C	SG	CT
4/8/2008	C	SG	SHEATH CLEANING
4/8/2008	B	SG	1.00 TIME STAMP 9:33am (T) by CS
4/8/2008	B	SG	1.00 APPOINTMENT (AP) by CS
4/8/2008	B	SG	1.00 ADMITTING BY LISA (CONVLN) by CS
4/8/2008	B	SG	1.00 EQUINE ANNUAL VACCINATIONS (Z4ANN) by CS
4/8/2008	B	SG	1.00 VEWT (4VEWT) by CS
4/8/2008	B	SG	1.00 RABIES (4RV) by CS
4/8/2008	B	SG	1.00 FLU-RHINO (4FR) by CS
4/8/2008	B	SG	1.00 STREP/STRANGLES (4STR) by CS
4/8/2008	B	SG	1.00 PREVENILE VACCINE (4WV) by CS
4/8/2008	B	SG	1.00 DIGITAL COGGINS TEST (4DCT) by CS
4/8/2008	B	SG	1.00 SHEATH CLEANING EQUINE (Z4S) by CS
4/8/2008	B	SG	.50 cc of IV:___ACEPROMAZINE INJ 10MG/ (ACEINJ) by CS
4/8/2008	B	SG	1.50 cc of IV:___XYLAZINE 100 MG/ML (X) by CS
4/8/2008	B	SG	1.00 THANK YOU! DR. GUYNN (SG) by CS
4/8/2008	B	SG	1.00 TIME STAMP 10:23am (T) by CS
4/8/2008	B	SG	1.00 DISCHARGE BY LISA (CONVLN) by CS
8/7/2007	B	SG	100.00 cc of RX:___BANAMINE/FLUNIXIN 50MG (BANA) by CS
8/7/2007	C	SG	#00135285 EXP.: 9/01/09

B:Billing, C:Med note, CB:Call back, CK:Check-in, CM:Communications, D:Diagnosis, DH:Declined to history, E:Examination, ES:Estimates, I:Departing instr, L:Lab result, M:Image cases, P:Prescription, PA:PVL Accepted, PB:problems, PP:PVL Performed, PR:PVL Recommended, R:Correspondence, T:Images, TC:Tentative medi note, V:Vital signs

Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
Address: 836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Age: 12 Yrs. 8 Mos.
Color: Cream/Palomino

Breed: Quarter Horse, American
Sex: Gelding

Date	Type	Staff	History
8/7/2007	C	SG	1 ML FOR EVERY 100 LBS IN TH MUSCLE.
8/7/2007	C	SG	NO MORE THAN EVERY 12 HRS. AS NEEDED
8/7/2007	C	SG	FOR PAIN AND OR FEVER.
8/7/2007	B	SA	1.00 DISCHARGE BY RAVEN (CONVLN) by CS
8/18/2006	B	DW	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
8/18/2006	C	DW	FREEZE BRAND
8/18/2006	B	DW	1.00 TIME STAMP 10:11am (T) by CS
8/18/2006	B	DW	1.00 APPOINTMENT (AP) by CS
8/18/2006	B	DW	1.00 ADMITTING BY SANDRA (ASC) by CS
8/18/2006	B	DW	1.00 BRAND/FREEZE-EQUINE (4FB) by CS
8/18/2006	B	DW	1.00 THANK YOU! DR. WEISS (DW) by CS
8/18/2006	B	DW	1.00 DISCHARGE BY MAURA (DMR) by CS
8/18/2006	B	DW	1.00 TIME STAMP 10:38am (T) by CS
4/15/2005	B	JE	1.00 COMMENT TO HISTORY ONLY (COMH) by CS
4/15/2005	C	JE	ANNUAL VAX, COGGINS, XRAY KNEE
4/15/2005	B	JE	1.00 TIME STAMP 10:46am (T) by CS
4/15/2005	B	JE	1.00 ADMITTING BY CATHY (ACH) by CS
4/15/2005	B	JE	1.00 COGGINS TEST (4CT) by CS
4/15/2005	B	JE	1.00 VEWT (4VEWT) by CS
4/15/2005	B	JE	1.00 FLU-RHINO (4FR) by CS
4/15/2005	B	JE	1.00 RABIES (4RV) by CS
4/15/2005	B	JE	1.00 WEST NILE VIRUS VACCINE (4WN) by CS
4/15/2005	B	JE	1.00 STREP/STRANGLES (4STR) by CS
4/15/2005	B	JE	2.00 X-RAY EQUINE/PER VIEW (4XR1) by CS
4/15/2005	B	JE	1.00 LABEL (LABEL) by CS

B:Billing, C:Med note, CB:Call back, CK:Check-in, CM:Communications, D:Diagnosis, DH:Declined to history, E:Examination, ES:Estimates, I:Departing instr, L:Lab result, M:Image cases, P:Prescription, PA:PVL Accepted, PB:problems, PP:PVL Performed, PR:PVL Recommended, R:Correspondence, T:Images, TC:Tentative medl note, V:Vital signs

Patient History Report

Client: SANTERRE, JUDY (3605382)
Phone: (512) 480-5670
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SMITHVILLE, TX 78957

Patient: HARVEY (32301)
Species: Equine
Breed: Quarter Horse, American
Age: 12 Yrs. 8 Mos.
Sex: Gelding
Color: Cream/Palomino

Date	Type	Staff	History
4/15/2005	C	JE	#
4/15/2005	C	JE	LAT AND AP//
4/15/2005	B	JE	3.00 cc of IV:___XYLAZINE 100 MG/ML (X) by CS
4/15/2005	B	JE	1.00 THANK YOU! DR. WHITWORTH (CONVLN) by CS
1/29/2005	B	LA	100.00 cc of RX:___BANAMINE/FLUNIXIN 50MG (BANA) by CS
1/29/2005	B	LA	10.00 each of RX:___NEEDLE 19G 1 1/2 (NEED19) by CS
10/9/2004	B	LA	1.00 RX:___WEST NILE VIRUS (CONVLN) by CS
9/13/2004	B	LA	1.00 WEST NILE VIRUS VACCINE (4WN) by CS
3/18/2004	B	LA	1.00 of COMMENT TO HISTORY ONLY (COMH) for $0.00 by CS
3/18/2004	C	LA	CASTRATE TODAY/DIDN'T ACE HIM
3/18/2004	B	LA	1.00 of TIME STAMP 10:31am (T) for $0.00 by CS
3/18/2004	B	LA	1.00 of ADMITTED BY JANET (AJM) for $0.00 by CS
3/18/2004	B	JE	1.00 of CASTRATE>2YRS (4C1) for $65.00 by CS
3/18/2004	B	JE	12.00 of ADM:__KETAMINE 100MG/ML (4ADM) for $51.46 by CS
3/18/2004	B	JE	5.00 of ADM:__XYLAZINE 100 MG/ML (4ADM) for $11.60 by CS
3/18/2004	B	JE	1.00 of PHONE/RECALL EQUINE (4P) for $0.00 by CS
3/18/2004	B	JE	1.00 of EQUINE ANNUAL VACCINATIONS (4ANN) for $0.00 by CS
3/18/2004	B	JE	1.00 of VEWT (4VEWT) for $17.50 by CS
3/18/2004	B	JE	1.00 of RABIES (4RV) for $15.00 by CS
3/18/2004	B	JE	1.00 of FLU-RHINO (4FR) for $22.00 by CS
3/18/2004	B	JE	1.00 of STREP/STRANGLES (4STR) for $15.00 by CS
3/18/2004	B	JE	1.00 of WEST NILE VIRUS VACCINE (4WN) for $22.00 by CS
3/17/2004	B	DW	2.00 of RX:___ACEPROMAZINE INJ 10MG/ (4RXFL1) for $8.65 by CS
3/17/2004	C	DW	#00086618 EXP.: 0/00/00
3/17/2004	C	DW	GIVE ORALLY OR IN MUSCLE

B:Billing, C:Med note, CB:Call back, CK:Check-in, CM:Communications, D:Diagnosis, DH:Declined to history, E:Examination, ES:Estimates, I:Departing instr, L:Lab result, M:Image cases, P:Prescription, PA:PVL Accepted, PB:problems, PP:PVL Performed, PR:PVL Recommended, R:Correspondence, T:Images, TC:Tentative medl note, V:Vital signs

Patient History Report

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Patient: HARVEY (32301)
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schedule, charging, that type thing. You type in your records. You know, we -- we're paperless, so we don't write down. We just type them in the computer. 11:26AM 11:26AM 11:27AM

Q. Okay. Got you. All right. And I did notice that Harvey had come in with something on his front chest, some kind of gash in his front chest, but that was back in '09 and I now know that you weren't there then. 11:27AM 11:27AM 11:27AM 11:27AM 11:27AM

A. I was not. 11:27AM

Q. Okay. In fact, you might have been a senior in high school at that time. 11:27AM 11:27AM

A. No, I was in veterinary school. 11:27AM

Q. Oh. 11:27AM

A. I hope anyway. 11:27AM

Q. All right. But you can -- I just want to find the first place where we know that Harvey came into the vet clinic. And the place that I found it was on the 20th, and I think that it starts on Page 7 -- 6 and -- it's kind of backwards, right? It's kind of chronologically backwards, like an e-mail chain almost? 11:27AM 11:27AM 11:27AM 11:27AM 11:27AM

A. Yeah, it's like -- yeah, I was going to say it is backwards because this is the very last thing up front. 11:27AM 11:27AM 11:27AM

Q. So if we go back to 6 and 7 -- 11:27AM

A. Uh-huh. 11:28AM

Q. -- that's where we find -- 11:28AM

A. That's where -- the first day of arrival is the 20th. 11:28AM

Q. Right. 11:28AM

A. Yes. 11:28AM

Q. And that was Dr. Mosley, right? 11:28AM

A. Yes. 11:28AM

Q. Okay. That saw him then. 11:28AM

A. Yeah. It has your initials by "Staff." 11:28AM

Q. Got it. Okay. 11:28AM

A. Because the previous page was when he came in in July for injuries. So that's old. 11:28AM

Q. Okay. And I was referred to this book as being the bible, so to speak, of things, "Manual of Equine Emergencies, Treatment and Procedures," James Orsini and Thomas -- I'm going to say Divers. 11:28AM

A. Divers. Uh-huh. 11:28AM

Q. Is this the book? 11:28AM

A. That's a good book, yes. 11:28AM

Q. Is there any more authoritative than this that tells us what the generally accepted practice is for equine -- management of equine emergencies? 11:28AM

A. No, that's a really good book. 11:28AM

Q. Is there any that's more accepted than this one? 11:28AM

A. Not that I know of. 11:28AM

Q. Okay. And so I went and looked at the protocol for lacerations over a synovial joint. 11:28AM 11:29AM

(Exhibit 12 marked) 11:29AM

Q. (BY MS. ALLEN) And if you needed to compare it, I'll be happy to loan you the book, but I copied some things out marked as Exhibit 12. 11:29AM 11:29AM 11:29AM

A. Okay. 11:29AM

Q. Some sections on lacerations. Can you take a look at that and if you want to -- need to confirm that it's exactly the same, I'll be happy to pass the book over. 11:29AM 11:29AM 11:29AM 11:29AM

A. Oh, no. It looks like it. 11:29AM

Q. This is something you're familiar with, right? 11:29AM

A. Yes. 11:29AM

Q. Okay. 11:29AM

A. (Reviewing document.) 11:29AM

Q. I had a copy of that that I was going to read from myself, but I guess I'll just have to read out of the book. I don't know what I did with it. 11:29AM 11:29AM 11:29AM

And that highlighting, I know you know, didn't -- wasn't in the book. 11:29AM 11:30AM

A. No. 11:30AM

Q. I added that. 11:30AM

A. Yeah. 11:30AM

Manual of Equine Emergencies

Treatment and Procedures

Second Edition

James A. Orsini
Thomas J. Divers

SAUNDERS

- If ultrasound examination is needed the results confirm complete disruption of a supporting structure.

Types of Luxation

Lower Limb Luxation

- Necessitates reduction and external coaptation.
- If the luxation is open, debridement of tissue if necessary and copious lavage of the joint are needed before cast application.
- If the patient is to be transported to another facility for treatment, protect the limb as described for fractures.

Luxation of the Scapulohumeral and Shoulder Joint

- These fractures are rare and involve rupture of some or all of the soft tissues that stabilize this joint, including the following:
  - Biceps brachii
  - Supraspinatus muscles
  - Tendon of insertion of the infraspinatus muscle
  - Joint capsule

Stifle Luxation

- Involves damage to at least one collateral ligament in addition to one or more cruciate ligaments.
- Damage to the menisci often occurs.
- The prognosis for use is very poor; degenerative joint disease (osteoarthritis) is a common sequela.
- The exception is *patellar luxation* (lateral luxation) that is surgically managed in foals and usually is not a traumatic event necessitating emergency treatment. Dorsal patella luxation occurs in adults and is usually a result of trauma. It can also have a good prognosis.

Luxation of the Hip and Coxofemoral Luxation

- Usually result in disruption of the surrounding joint capsule and the round and accessory ligaments of the femur.
- Anesthesia is needed to reduce the luxation, and maintaining reduction is difficult in all but the smallest patients.
- Arthritis is generally the sequela.

Carpometacarpal Luxation and Subluxation

- Injury to the periarticular soft-tissue structure and proximal metacarpals II and IV as a result of trauma, usually a kick.
- Subluxation is reduced under sedation, and a PVC splint is placed on the limb dorsally and laterally. The splint should extend from the foot to the proximal radius and be incorporated in a cotton bandage.
- A radiograph of carpal region is obtained for assessment of severity of injury.
- Treatment options include:
  - Full-leg external coaptation.

CAUTION: Plaster-based materials (plaster of Paris) and casting tape (synthetic materials) can cause soft-tissue problems, especially over the accessory carpal bone.

  - Internal fixation to stabilize lateral or medial aspects of the carpus.
- Degenerative joint disease of the carpometacarpal joint is a sequela.

Prognosis

- Closed luxation of the distal tarsal, metacarpophalangeal or metatarsophalangeal, and proximal interphalangeal joints is successfully managed with long-term (12 weeks) external coaptation (cast application). Arthrodesis of the proximal interphalangeal (pastern) joint is commonly performed.
- The limb is cast in normal alignment, the foot included in the cast. General anesthesia is required for correct limb orientation. *Arthritis is a potential sequela*, so advise the owner of this.
- Horses treated with external coaptation often are functional.
- Luxation of the distal interphalangeal joint is rare and is associated with advanced degenerative joint disease and biaxial neurectomy used to manage chronic pain. The prognosis is poor. Arthrodesis is difficult.
- Affected horses with luxation of the shoulder or hip that spontaneously reduces usually recover function of the joint.
- Patients that need manual reduction of the luxation under general anesthesia have a guarded prognosis for a pain-free joint.
- If reduction of the luxation is not maintained the joint becomes nonfunctional and arthritis results; euthanasia is recommended.
- Luxation of the stifle generally is associated with severe damage to supporting structures; limb instability makes treatment impossible.

INFECTION

- Non–weight-bearing lameness often indicates infection in the following:
  - A joint
  - Bursa
  - Tendon sheath
  - Other soft-tissue structure
- Sepsis often is secondary to a laceration or puncture wound that occurred before and was not diagnosed or treated early and aggressively to prevent contamination progressing to infection.
- Lacerations, punctures, and management of secondary infections are covered in the following section.

Summary

A patient unable or unwilling to bear weight on a limb needs rapid intervention to reduce anxiety and prevent further damage to the limb. Figure 39–5 summarizes the steps required to minimize damage, establish a preliminary diagnosis, and prepare for referral to a medical facility.

LACERATIONS

- *One of the most common reasons for emergency assistance.*
- The initial and most important first step: Determine which structures are involved.
- *Adequate treatment is impossible until all affected structures are identified.*

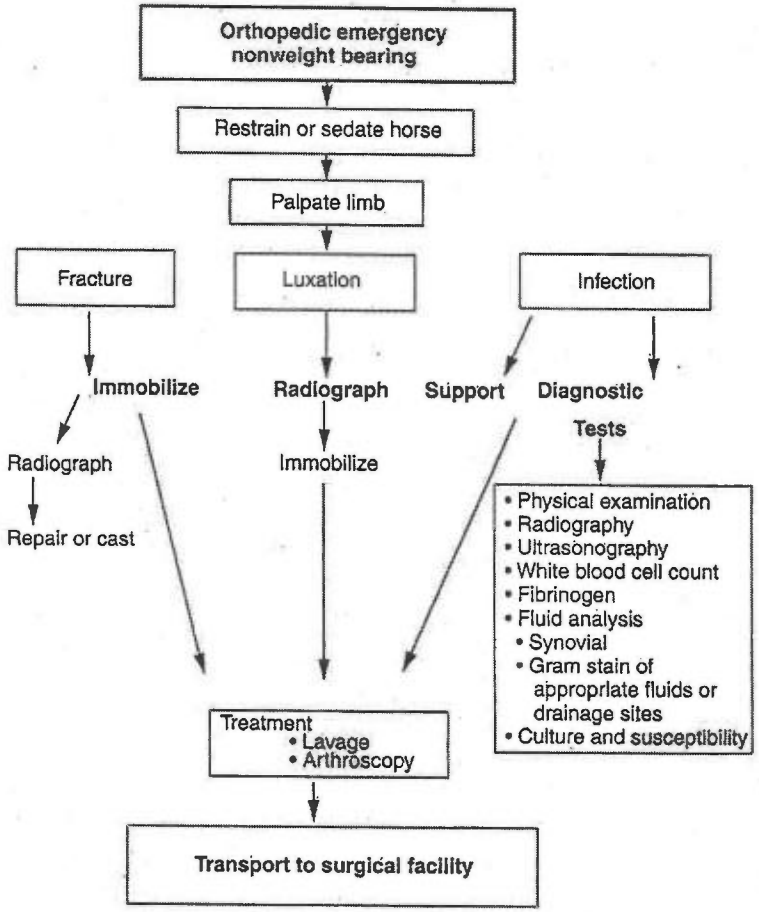


FIGURE 39-5. Algorithm for emergency management of non–weight-bearing problems.

- The patient is restrained for evaluation, then treated or referred to a surgical facility if needed.
- Referral is based on whether the injury requires facilities or expertise not available locally and is made after the initial examination.
- Lacerations necessitating special treatment include
  - Tendons and tendon sheaths
  - Extensive degloving injuries
  - Periosteum
  - Veins and arteries
  - Coronary band and hoof wall
  - Joints

- Lacerations involving less critical structures are cleaned, debrided, and sutured primarily or bandaged for several days and then sutured (delayed primary closure).
- With any laceration, adequate *tetanus prophylaxis* and appropriate antibiotic therapy are mandatory.

Lacerations Requiring Special Care

Lacerations to Flexor Tendons and Their Sheaths

- Tranquilize the patient and assess the damaged structures.
- The depth and cause of the laceration determine which structures are injured or severed.
- Superficial lacerations cause damage to the flexor tendon sheath only.
- Deeper lacerations affect first the superficial digital flexor tendon, next the deep digital flexor tendon, and then the suspensory ligament.
- Degree of damage, contamination, duration of injury, temperament, and extended use contribute to the prognosis. *The prognosis is best if:*
  - *Blood and nerve supply are intact*
  - *Contamination is minimal*
  - *Injury is located outside the tendon sheath*
- If a flexor tendon or the suspensory ligament is completely severed, changes in the axial and flexure alignment of the limb are useful in determining the degree of damage.
- Complete laceration of the superficial flexor tendon causes the fetlock to drop slightly. When both the superficial and deep flexor tendons are severed, the fetlock drops slightly and the toe dorsiflexes and *elevates with weight bearing.*
- *Severe* loss of fetlock support results from severance of the superficial and deep flexor tendons *and* the suspensory ligaments, accompanied by toe elevation.
- "Breakdown injuries" (traumatic disruption of the suspensory apparatus) demonstrate the same bony malalignment and are caused by rupture of the suspensory ligament, distal sesamoid ligaments, or biaxial fracture of the sesamoid bones. Radiographs depict the involved structures.

TO TRANSPORT

- Apply a splint to minimize hyperextension of the limb. This limits tendon end distraction and preserves blood and nerve supply. Several commercially produced splints can be used:
- Leg-Saver Splint (preferred), Kimzey, Inc., Woodland, CA
- A board splint made from readily available materials can be used if necessary.

Materials Needed for a Board Splint

- Leg bandages
- 1 roll of cotton padding
- Elastic tape
- 1 hardwood board, 40 cm long × 12 cm wide × 2 cm thick
- Hand drill
- Steel drill bit
- Heavy wire

- Clean lacerations of the coronary band carefully and place a large, horizontal mattress suture of #1 or #2 nonabsorbable suture material to bridge the defect.
- Minimizing the gap in the coronary band defect minimizes the hoof wall defect.
- If a portion of the coronary band is displaced, repair it at the time of injury.
- If such a wound heals by secondary intention, the abnormal hoof wall growth requires lifelong hoof wall management because of the defect.
- Lacerations of the hoof wall are examined for the following:
  - Depth of the defect
  - Instability of the hoof capsule
  - Involvement of the distal interphalangeal joint and soft tissues
- To evaluate deep lacerations properly, use local or general anesthesia.
- To transport, place a clean, well-padded bandage around the foot, including the sole, and extend the bandage to the fetlock joint.
- If bleeding is excessive, use several layers of cotton applied over the initial bandaging material.
- Placing a plastic bag between cotton layers helps confine the hemorrhage, keeps the outer layers from becoming blood-soaked, and minimizes contamination during transport.
- When the wrap is complete, place impervious tape (duct tape) over the outside to waterproof and provide wear resistance until repair.
- Broad-spectrum antibiotic therapy (see Table 39–3) and tetanus prophylaxis are recommended.
- After cleaning and debriding a hoof wall laceration, achieve stability by using a slipper cast (Fig. 39–8) or by using a bar shoe and bandages.
- Hoof wall lacerations require 4-8 months to heal by new hoof formation rather than healing from side to side.

FIGURE 39–8. A short, slipper cast can be used to stabilize lacerations of the hoof wall or coronary band. The cast can be applied with the horse standing and should extend to just beneath the fetlock joint.

Joint Lacerations

- A joint laceration is an emergency and is confirmed if bone and cartilage are seen.
- Even if the joint surface is not seen, the proximity of the laceration to the joint may suggest involvement.
- If joint involvement is even suspected, broad-spectrum antibiotics (see Table 39–3) are started immediately, followed by additional diagnostic procedures to rule out joint involvement.

NOTE: Prognosis is markedly improved if antibiotics are started within 24 hours of injury.

- Techniques to determine joint involvement include:
  - Sedate the patient.
  - Surgically prepare the opposite side of the joint, inject sterile saline solution intraarticularly, and check to see whether it communicates with the laceration.
  - Sterile methylene blue dye can be used.
  - An alternative is to inject sterile contrast medium and obtain a radiograph focused on the lacerated area to determine whether the joint capsule is open.

NOTE: Plain radiographs with gas density in the joint indicate communication with the skin.

- *If the joint is involved, place the patient under general anesthesia and lavage the affected joint copiously.*
  - After sterile preparation, place a 14-gauge needle intraarticularly opposite the laceration.
  - Infuse a continuous ingress flow of lactated Ringer's solution plus 10% DMSO through the joint during debridement of the wound.
  - Infusion of an antibiotic solution after lavage is advocated in addition to broad-spectrum systemic antibiotics.
  - Avoid antibiotics with a low pH; they are irritating to the synovium.
  - Crystalline penicillin (1×10^6 IU) or a solution of gentamicin (50 mg/ml) or amikacin (250 mg/ml) buffered with sodium bicarbonate (1 mEq/ml) is safely infused after thorough lavage.
  - Gentamicin is supplied at a pH of 2.0, and a near-normal pH is achieved by means of adding 2 ml of sodium bicarbonate to 1 ml of gentamicin.
  - If the laceration is clean and can be closed primarily, maintain an intraarticular closed-suction drain for 2-4 days.
  - Apply antibiotic ointment at the drain exit site and cover the area with a sterile bandage.
  - When fluid is removed from the suction system, be careful not to contaminate the drain and the exit portal.
  - Superficial contamination can lead to ascending infection and therefore necessitates careful monitoring.
  - After drain removal (<10 ml q6-8h), leave sterile wraps in place until joint fluid is no longer evident on the bandage.
- *If the patient becomes progressively more lame as the laceration heals, suspect infection.*
- Aspiration of joint fluid for cytologic examination and culture and susceptibility testing is essential in determining the cause.

- A white blood cell count >30,000 cells/dl in synovial fluid is presumptive evidence of infection.
- Repeat culture and sensitivity testing of the fluid until sepsis is ruled out.
- If antibiotic therapy has been discontinued, reinstitute it.
- Sequential joint lavage, with continuous suction drainage between, reduces the bacterial count and joint destruction caused by the septic inflammation.
- Joint lacerations carry a guarded prognosis: Early, aggressive diagnosis and treatment maximize the chance for recovery.

PUNCTURE WOUNDS

- Punctures into synovial structures, including joints, tendon sheaths, and bursae, are emergencies:
  - Introduction of bacteria into these closed spaces can result in life-threatening infection.
  - Joint and tendon sheath punctures are managed as small lacerations to these structures.
  - Aspiration of synovial fluid for culture and sensitivity, meticulous cleaning of the area, copious lavage, broad-spectrum antibiotic therapy (see Table 39–3), and bandaging are recommended.
- *Puncture wounds of the sole* with injury to the frog or the bars are likely to involve deeper structures, such as the digital cushion, navicular bursa, deep digital flexor tendon and sheath, and distal interphalangeal joint.
- If these structures are involved, *conservative treatment with soaking and systemic treatment alone is not sufficient to prevent infection.*
- If a puncture wound is found in this area, aggressive diagnosis and treatment are required.
- Obtain radiographs of the foot with the penetrating object in place, if possible, to give an indication of the depth of penetration.
- If the object or foreign body has been removed, locate, open, and clean the tract and introduce a sterile probe before obtaining the radiograph. *Do not force* the probe into the deeper tissues.
- Extension of a tract can be delineated with contrast medium.
- If radiographs indicate that the navicular bursa, deep digital flexor tendon sheath, or distal interphalangeal joint has been entered, synovial samples of these structures are confirmatory for involvement:
  - Distal interphalangeal joint fluid is obtained by means of aspiration 1 cm above the coronary band, 1 cm medial or lateral to the extensor tendon (Fig. 39–9*b*).
  - Flexor tendon sheath fluid is obtained by means of aspiration of the most fluctuant area of the sheath (Fig. 39–9*a*).
  - The navicular bursa fluid is difficult to aspirate. Aseptically prepare the area on the lateral aspect of the pastern proximal to the collateral cartilage; insert a 20-gauge, 1.5-inch (3.8 cm) needle palmar to the second phalanx and dorsal to the deep digital flexor tendon. Advance the needle toward the sole of the medial hoof (Fig. 39–9*c*).
- If the white blood cell count is increased with degenerate neutrophils, suspect infection and lavage the joint or tendon sheath, ideally with the patient under general anesthesia.

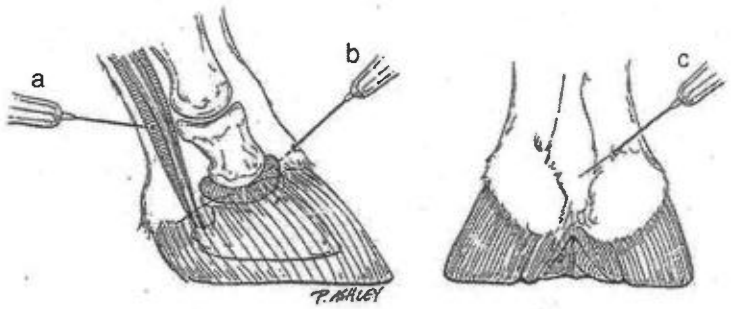


FIGURE 39–9. Placement of needles for centesis of the deep digital flexor tendon sheath *(a)*, distal interphalangeal joint *(b)*, and navicular bursa *(c)*.

- If the navicular bursa is involved, make a surgical window into the bursa from the frog and establish ventral drainage (Fig. 39–10). This is called a *street nail procedure.*
- Endoscopy of the navicular bursa is *now* the preferred technique for management of contaminated and septic bursa (see p. 00).
- Punctures are misleading because they appear benign when first encountered; thus aggressive therapy is frequently delayed until clinical signs of infection occur.
- *At this point the prognosis is guarded for return to athletic function.*
- When penetration is suspected, aggressive treatment is recommended.
- Perform lavage while the patient is standing. Use xylazine and butorphanol sedation (see Table 39–1). Most horses need general anesthesia.
- Bandaging after lavage includes sterile dressings over the puncture site. If a portion of the sole or frog is removed, bandaging is needed until horn tissue covers the area. Fabricate a treatment or medicine plate shoe that allows easy bandage changes to minimize the work and cost of daily treatment.
- Keep the foot dry and clean and limit exercise until the wound is covered with granulation tissue and a cornified layer forms.

Summary

- Many equine orthopedic emergencies manifest themselves when the patient bears all or some weight on the affected limb.
- This is true in cases of minor, or incomplete, fractures, lacerations, and puncture wounds.
- Because the patient appears to be in less distress, the injury is not viewed as serious or necessitating emergency care.
- *If treatment is not initiated soon after injury, the sequela can be life threatening.*
- Fig. 39–11 provides guidelines for managing injuries in which the patient has an injury that allows weight bearing and is managed as an emergency.

Q. Let's see if I can find my copy of that. Well, darn. 11:30AM

A. Do you need this? 11:30AM

Q. I can do without it. If you'll help me and tell me what page we start on. Page -- yeah. 11:30AM

A. 357. 11:30AM

Q. 357. And this is the section that's talking about emergencies that involve the musculo- -- I'm not going to say that right -- musculoskeletal -- 11:30AM

A. Skeletal. 11:30AM

Q. -- system. 11:30AM

A. Uh-huh. 11:30AM

Q. Right? 11:30AM

A. (Nods affirmatively.) 11:30AM

Q. You'll have to say yes or no. 11:30AM

A. Yes. 11:30AM

Q. Okay. And by the way, I didn't ask you, but I have seen the term "joint infection." I've seen the term "septic joint." 11:30AM

Are those the same thing? 11:30AM

A. Those are the same. 11:30AM

Q. Okay. Sepsis in a joint, that's the same thing? 11:30AM

A. Yes, ma'am. 11:30AM

Q. Okay. So those are interchangeable terms? 11:30AM

A. Yes. You can use them in between. 11:30AM

Q. Okay. And so what the authoritative treatise or book says about infections is that "Sepsis often is secondary to a laceration or puncture wound that occurred before and was not diagnosed or treated early and aggressively to prevent contamination progressing to infection." 11:31AM

Do you see that? 11:31AM

A. Yes. 11:31AM

Q. And that's true, isn't it? 11:31AM

A. Yes. 11:31AM

Q. Okay. And that's why it's critical to treat it early and aggressively, correct? 11:31AM

A. Yes. 11:31AM

Q. Okay. And for equine emergencies, which is what he calls this, an equine emergency, what's the window of time for treatment generally? What's the accepted practice? 11:31AM

A. You like to see a wound within 24 hours. 11:31AM

Q. Okay. And then if we continue on in the treatise, it says, "Lacerations necessitating special treatment include" lacerations of the joint, right? 11:31AM

A. Yes. 11:31AM

Q. And you agree with that, don't you? 11:31AM

A. Sure. 11:31AM

Q. Okay. And I didn't highlight it, but it says here, "Lacerations involving less critical structures are cleaned" -- and is that debrided or debrided? 11:31AM 11:32AM 11:32AM

A. Debrided. 11:32AM

Q. -- "debrided" -- 11:32AM

A. Uh-huh. 11:32AM

Q. -- "and sutured primarily or bandaged for several days and then sutured." 11:32AM 11:32AM

And that is exactly what Dr. Mosley did when Harvey came in, right? 11:32AM 11:32AM

A. She cleaned and sutured it. 11:32AM

Q. So she treated it as a laceration involving a less critical structure, correct? 11:32AM 11:32AM

A. Yes. 11:32AM

Q. Okay. And then one of the lacerations requiring special care is flexor tendons, and we can skip that because that's not what we're dealing with. 11:32AM 11:32AM

A. The tendon wasn't affected. Uh-huh. She -- she treated the skin. She stitched the skin. 11:32AM 11:32AM

Q. Right. She didn't do anything with regard to the joint, correct? 11:32AM 11:32AM

A. I don't believe so. 11:32AM

Q. Okay. And then it talks on Page 365 about joint lacerations. And it says, "If joint involvement is even suspected" -- well, let's back up a minute. It 11:32AM 11:33AM

says, "Even if the joint surface is not seen, the proximity of the laceration to the joint may suggest involvement." 11:33AM

And you agree with that, don't you? 11:33AM

A. It's possible, yeah. 11:33AM

Q. Okay. And "If joint involvement is even suspected, broad-spectrum antibiotics" -- refers us to a table -- "are started immediately, followed by additional diagnostic procedures to rule out joint involvement," correct? 11:33AM

A. Yes. 11:33AM

Q. And then he lists the protocol for those procedures, and we'll talk about that in a minute. 11:33AM

But let's stop there just for a second. And he refers us to a table that I didn't photocopy because I didn't realize I needed to. But I'm now showing you Table 39-3, "Broad-Spectrum Antibiotic Regimens for Orthopedic Emergencies." 11:33AM

Do you see that in the Divers book? 11:33AM

A. Yes. 11:34AM

Q. And this, again, is the -- considered the authoritative guide on management of these types of injuries, correct? 11:34AM

A. Yes. 11:34AM

Q. Okay. And I did not see SMZ tablets on 11:34AM

Table 39-3. Do you? 11:34AM

A. It's the same thing as trimethoprim sulfa (indicating). 11:34AM

Q. You think that's the same thing? 11:34AM

A. Yeah. You can -- you can people call it different things, SMZ, trimethoprim -- 11:34AM

THE REPORTER: Slow down just a little. 11:34AM

THE WITNESS: Oh, sorry. 11:34AM

A. It's a sulfa antibiotic (indicating). 11:34AM

Q. (BY MS. ALLEN) And what is the dosage that is -- 11:34AM

A. It says 20 to 30 milligrams per kilogram by mouth twice a day. 11:34AM

Q. By mouth? 11:34AM

A. PO is per os. 11:34AM

Q. I thought it was IV. No? 11:35AM

A. Not -- not sulfa. The only orals that they offer are the sulfas and enrofloxacin. The rest of them are either IM or IV, all the injectables. 11:35AM

Q. Okay. All right. And so the -- I'm sorry. The dosage is? You told me and I was -- 11:35AM

A. Oh, sorry. 20 -- 11:35AM

Q. -- thinking of somewhere else. 11:35AM

A. 20 to 30 milligrams per kilogram twice a day. 11:35AM

Q. So for a mature horse like Harvey, the dosage 11:35AM

is what?

A. I can calculate it, if you want. Thousand -- because they're -- each tablet is 916 milligrams. I'd have to calculate it.

Would you like me to?

Q. If you would, that would be great.

A. Sure. I have to get a calculator out. So 9.4 tablets twice a day.

Q. Okay.

A. That would be the dosage I would use on calculation.

Q. And do they say for how long of a time?

A. It doesn't in this chart, but I'm sure somewhere it does.

Q. Do you know how long the time is?

A. I typically treat a wound for seven to ten days. On follow-up recheck and then, you know, see what the wound is looking like. You can prescribe more or if you need to switch or whatever you need to do at that time.

Q. If in 7 to 14 days the wound is maybe healed on the outside but the leg is swollen and it's hot and that sort of thing, what is the accepted practice for dealing with that situation?

A. Definitely you can prescribe more antibiotics.

11:35AM 11:35AM 11:35AM 11:35AM 11:35AM 11:35AM 11:35AM 11:35AM 11:36AM 11:36AM 11:36AM 11:36AM 11:36AM 11:36AM 11:36AM 11:36AM 11:36AM 11:36AM 11:36AM

September 2013 – August 2014

September

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

October

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

November

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

December

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

January

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

March

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

April

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

May

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

July

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

August

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Rustejousky
EXHIBIT NO. 13
2-29-16
Julie A. Jordan

- Mosely
- Moore
- Weiss
- Schroeder
- Lucy

Hurd, Kate

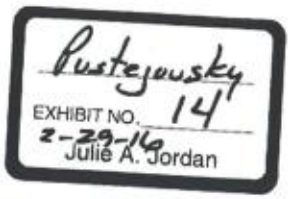
From: Bastrop Veterinary Hospital BVH <bastropvet@hotmail.com>
Sent: Tuesday, December 08, 2015 1:45 PM
To: Jim Goldsmith
Subject: Fw: Fwd:
Attachments: photo.JPG

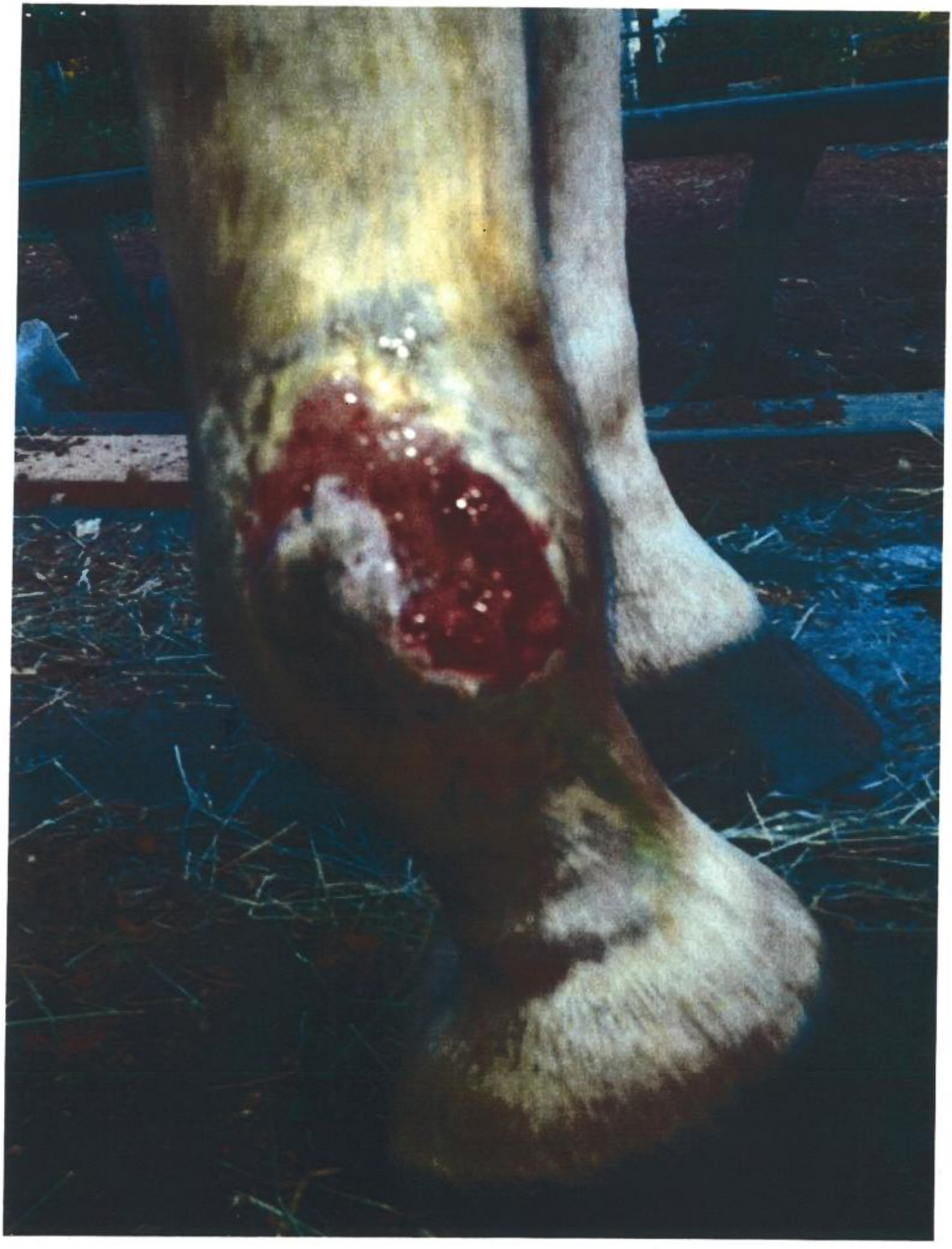
Forwarded email per request on 12/8.
Janet Fitzsimon-Barr, Practice Manager
Bastrop Vet Hospital
512-321-5386

From: J Santerre <jtex363@gmail.com>
Sent: Friday, October 4, 2013 9:29 AM
To: bastropvet@hotmail.com
Subject: Fwd:

Drs.,
Attached is a photo of Harvey's injury. I don't know if this is where he is supposed to be or not. I've been lucky enough to never have to deal with an injury this severe. I am concerned that this wound is still so open. I gave him the last of his antibioltic this morning. Yesterday, he didn't eat with the usual vigor and I took his temperature but it was normal (just above 100). He ate better last night and this morning. He's pooping and drinking water normally. I am hydroing for 10 minutes every night and changing his bandage, using the Granulex. He doesn't limp or appear to be in pain, except at the wound site. It just looks awful. If you want to see him, I can bring him in tomorrow morning (or sooner if you think it's serious).
Judy

---------- Forwarded message ----------
From: **Judy** <jtex363@gmail.com>
Date: Fri, Oct 4, 2013 at 8:44 AM
Subject:
To: Jtex363@gmail.com





You can change your antibiotics, you know, try something different, whatever you need. 11:36AM

Q. Well, what tells you what you should do? 11:36AM

A. Based on what your infection you're suspecting, that's typically what antibiotic you pick. 11:36AM

Q. What infections are most common with a joint infection? What bacteria? 11:37AM

A. Normally it can be bacteria from the skin or something they can pick up from the ground, whether it be a staph, you know, things off their skin, you know. A lot of times you like broad spectrum because you don't really know what the bacteria is going to be. 11:37AM

Q. But when it's resistant or doesn't respond to the broad spectrum that you've given -- 11:37AM

A. Uh-huh. 11:37AM

Q. -- is it your view that it's accepted protocol and customary practice to continue to give the same broad spectrum? 11:37AM

A. You can switch, switch to something different. 11:37AM

Q. Is that the generally accepted practice under that circumstance, to switch to something different? 11:37AM

A. Usually. The only thing you is you can see all the other antibiotics have to be given as injectables and some owners prefer orals because horses eat anything, so it's easy to treat them with orals, 11:38AM

whereas giving IV injections is hard -- or IM injections in some horses. And so, unfortunately, we didn't have a lot of oral options, so it's one of our more common antibiotics used. 11:38AM

Q. But if it's not working, are you going to just let the owner keep doing it because it's something that the owner is able to do? 11:38AM

A. You're right. Definitely would be rather to try something different. 11:38AM

Q. And to your point that feeding it can be easier, isn't it also true that feeding it doesn't guarantee that the horse is actually getting it? 11:38AM

A. Well, I mean, we treat horses orally all the time. If they don't eat on the feed, you can just mix it in some syrup or something and give it to them by mouth so you know they're getting it, like a paste. 11:38AM

Q. You can, but Judy Santerre was never advised that she ought to mix it up and give it like a paste, was she? 11:38AM

A. I'm not sure. 11:38AM

Q. Did you ever advise her of that? 11:38AM

A. I did not. 11:39AM

Q. Okay. Was -- do you know that there was never a time when the Bastrop people at the Bastrop Veterinary Hospital suggested to Judy that there be a change in the 11:39AM

antibiotics? 11:39AM

A. She just -- yeah. No. We just refilled the SMZ tabs. 11:39AM

Q. Right. And that is -- the standard of care would require that something different happen if over a two-and-a-half course month period SMZ wasn't working, right? 11:39AM

A. Exactly. 11:39AM

Q. And that just never got done, did it? 11:39AM

A. It did not. 11:39AM

Q. Okay. Could you look back with me at -- I believe it's Exhibit 12. Is that what we marked it or 11? 11:39AM

A. 11. 11:39AM

Q. 11, the patient history report. And tell me -- I'm looking now on Page 7 at Dr. Mosley's entries. 11:40AM

A. Okay. 11:40AM

Q. Is there any of these that is a diagnosis? I can't tell the code. I sense that the -- some of these are abbreviations. 11:40AM

A. It has the history -- so the abbreviations, HX is history, PE is physical exam, TX is treatment, and then the plan is, you know, where we're going from here. I mean, I don't see an actual definitive diagnosis, just what she found on her exam. 11:40AM

Q. Is there -- you said you didn't see a definitive diagnosis. 11:40AM

Did you see any kind of diagnosis? 11:40AM

A. Like I said, just exam findings, what they did and what they treated with. 11:40AM

Q. And when she says -- and you -- the TX, that's treatment? 11:40AM

A. Treatment. Uh-huh. 11:41AM

Q. Okay. It says, "WOUND CLOSED EASILY ON CAUDAL ASPECT." 11:41AM

A. That means back. So cranial is forward, caudal is back. Like anterior, posterior. 11:41AM

Q. Okay. 11:41AM

A. Just posterior. 11:41AM

Q. And -- but she says, "CRANIAL ASPECT WAS VERY TIGHT & DID NOT CLOSE COMPLETELY." 11:41AM

So that just means it didn't suture completely closed? 11:41AM

A. That means the tension on the skin, I guess, was too tight to bring it together fully. 11:41AM

Q. Okay. So there was a area of the wound that wasn't sutured closed? 11:41AM

A. Uh-huh. 11:41AM

Q. Okay. 11:41AM

A. The picture looks like it was closed, so I'm 11:41AM

not sure. 11:41AM

Q. Okay. And you can see in the plan that 11:41AM
Judy Santerre was sent home with SMZ tabs -- 11:41AM

A. SMZ. 11:41AM

Q. -- right? 11:41AM

A. Uh-huh. Uh-huh. That's the antibiotic. 11:41AM

Q. And was told change the bandage and hydro the 11:41AM
wound once daily and warned that the sutures might bust 11:41AM
out. 11:42AM

Now, why was it anticipated that the 11:42AM
sutures might bust out? 11:42AM

A. I bet it was because of the tension. She 11:42AM
noted that she couldn't close it and it was very tight. 11:42AM
So as they're putting pressure on it, that's probably -- 11:42AM
sometimes we bandage to help apply pressure. I guess 11:42AM
she was worried that they wouldn't hold. 11:42AM

Q. Okay. 11:42AM

A. And that's when you don't heal by primary 11:42AM
tension, you heal from secondary intention, which is the 11:42AM
body forming scar tissue and healing over. 11:42AM

Q. And, in fact, it didn't hold, right? 11:42AM

A. It -- I don't think it did. 11:42AM

Q. Okay. 11:42AM

A. No, it didn't. It didn't. 11:42AM

Q. That wasn't a surprise, I take it. 11:42AM

A. No, not by her. Huh-uh. 11:42AM

Q. Okay. And Judy was advised to keep it bandaged until it heals or scabs over? 11:42AM

A. Yes. 11:42AM

Q. To the best of your knowledge, Judy did all these things, right? 11:42AM

A. Yes. 11:42AM

Q. Okay. The SMZ tabs, we can look down and see that Dr. Mosley sent her home with 200 of them, right? 11:42AM

A. Uh-huh. 11:42AM

Q. And based on the calculations you did for us a little while ago, that, I think, would be -- 11:42AM

A. That's ten days. 11:43AM

Q. Ten days supply? 11:43AM

A. Uh-huh. 11:43AM

Q. So that fits in your seven- to ten-day window? 11:43AM

A. Yes. 11:43AM

Q. Okay. 11:43AM

A. And she probably was going to recheck in that time. 11:43AM

Q. Does it say anything in here about a recheck? 11:43AM

A. It doesn't. I would assume she communicated that with her. 11:43AM

Q. Okay. What are the side effects to SMZ, by the way? 11:43AM

A. You can see diarrhea. It's one of the most common things, colitis. 11:43AM

Q. Is there a recommended length of time for its use? 11:43AM

A. Typically with antibiotics, I don't like to use them more than 10 to 14 days straight. You can monitor for side effects. If they -- if you see a side effect, you definitely want to discontinue. 11:43AM

MR. GOLDSMITH: Kappy, whenever you get to a stopping point, may we take a short break? 11:43AM

MS. ALLEN: This is fine. 11:44AM

MR. GOLDSMITH: Okay. Good. Thank you. 11:44AM

(Recess taken from 11:44 a.m. to 11:54 a.m.) 11:44AM

(Exhibit 13 marked) 11:54AM

Q. (BY MS. ALLEN) So, Doc, I have gotten a calendar out because I just want to kind of keep track of the dates of these things. And so I've marked it as Exhibit 13. 11:54AM

A. Okay. 11:54AM

Q. And I've got colors down here for each of you guys. 11:54AM

And it was Dr. Mosley that saw Harvey on the 20th, is that right? 11:54AM

A. Yes. 11:54AM

Q. Okay. So I've put Dr. Mosley's color on September 20. 11:54AM

Do you see that? 11:55AM

A. Yes. 11:55AM

Q. Okay. Just to help us keep up with the dates and -- 11:55AM

A. Sure. 11:55AM

Q. -- who did what. 11:55AM

Now, and I think that what you told us is she gave him ten days' worth of SMZ, right? 11:55AM

A. Yes. 11:55AM

Q. So his SMZ that she sent him home with would have run out on -- 11:55AM

A. On Monday. 11:55AM

Q. On which day? Sorry? 11:55AM

A. The 30th. Monday the 30th. 11:55AM

Q. On the 30th. That's what I was thinking. Okay. So I'm just going to find a black pen somewhere in a minute and put a square box that on the 30th of September that SMZ would have been gone. 11:55AM

And if there had been no complications, that's when you would except the thing to be doing a whole lot better, right? 11:55AM

A. Sure. 11:55AM

Q. Okay. And then the next time somebody at the 11:55AM

Bastrop Veterinary Hospital saw Harvey, according to the records of the clinic was -- well, let me back up a minute. The next time the clinic was contacted about Harvey was when? 11:55AM 11:55AM 11:56AM 11:56AM

A. The 25th. 11:56AM

Q. Well, back up with me to the 21st. 11:56AM

A. 21st was a tetanus -- tetanus shot. 11:56AM

Q. And that's something that should have been done on the 20th, right? 11:56AM 11:56AM

A. Well, actually, yeah. 11:56AM

Q. Do you know why it wasn't done on the 20th? 11:56AM

A. But he had one back in July. Well, I'm not sure why it wasn't. But he did have one. 11:56AM 11:56AM

Q. Okay. 11:56AM

A. It's hard to booster it now. 11:56AM

Q. I just thought it was -- I couldn't understand why it wasn't done on the 20th. 11:56AM 11:56AM

A. Not unless he stayed overnight. Because sometimes when we post things, like you put your initials in that thank you sign, sometimes it does it the next day. 11:56AM 11:56AM 11:56AM

Q. Okay. 11:56AM

A. I'm not sure when it was given. 11:56AM

Q. It might have been something that simple as the computer program? 11:56AM

A. Yeah. Computer, yeah, glitch, because she put in her initials to put the thank you sign in. It might have -- I'm not sure, though. 11:56AM 11:56AM 11:57AM

Q. Makes sense. 11:57AM

And then on the 25th it looks like there's some Banamine dispensed? 11:57AM 11:57AM

A. Yes. 11:57AM

Q. And that was -- DW is Dr. Weiss? 11:57AM

A. Dr. Weiss. 11:57AM

Q. Okay. So on the 20 -- 11:57AM

A. 5th. 11:57AM

Q. -- 5th, Dr. Weiss -- September, right? 11:57AM

A. Yes. 11:57AM

Q. Dr. Weiss dispensed some Banamine? 11:57AM

A. Uh-huh. 11:57AM

Q. Okay. Do you know how that came about? 11:57AM

A. I'm sure it was a telephone call. 11:57AM

Q. By whom to whom? 11:57AM

A. I'm guessing Ms. Santerre to the clinic. 11:57AM

Q. Okay. Calling and saying the horse isn't doing any better? 11:57AM 11:57AM

A. Likely. 11:57AM

Q. Okay. 11:57AM

A. Or -- I mean, because I think she said -- because she had Banamine. So she told her continue it. 11:57AM

Maybe she was calling to refill it because she -- maybe she ran out. Most owners keep Banamine on hand for colics and things like that. 11:57AM

Q. Okay. But Dr. Mosley had prescribed the Banamine should be administered to Harvey -- 11:57AM

A. Yes. 11:57AM

Q. -- under these circumstances, right? 11:58AM

A. Yes. 11:58AM

Q. And so we're clear, Banamine is not an antibiotic, correct? 11:58AM

A. It's an antiinflammatory. 11:58AM

Q. All right. So it will have the effect, if it works, of hopefully reducing the swelling and the painfulness? 11:58AM

A. Pain. 11:58AM

Q. And so Dr. Mosley had prescribed for Judy to continue administering the Banamine, right? 11:58AM

A. Uh-huh. 11:58AM

Q. And it -- so it appears that she was doing that, correct? 11:58AM

A. Yes. 11:58AM

Q. Okay. Do you know whether Dr. Weiss when he spoke to Ms. Santerre on the 25th told her she ought to bring Harvey in for a checkup? 11:58AM

A. I don't know whether he spoke to her or not. 11:58AM

I'm not sure what -- there's nothing here. 11:58AM

Q. Okay. All right. And then -- so then there was a visit, correct? 11:58AM

A. On the 28th there was a recheck. 11:58AM

Q. Okay. And that was Dr. Mosley, right? 11:58AM

A. Yes. 11:58AM

Q. Okay. So let's see. September 28th? 11:58AM

A. Yes. 11:59AM

Q. That was a Saturday? 11:59AM

A. Yes, ma'am. 11:59AM

Q. Okay. I'm going to put Dr. Mosley down on Exhibit 13. 11:59AM

Have I got that right? 11:59AM

A. Yes. 11:59AM

Q. Okay. And what did she do at that time? 11:59AM

A. Looks like she examined it, removed the sutures, cleaned the wound and debriding it -- or no, I don't think -- I think she just cleaned it, topical and bandage and SMZs with a topical medication. 11:59AM

Q. All right. She gave 80 tablets, so is that four days' worth? 11:59AM

A. Four more days' worth, so a total of 14. 11:59AM

Q. So beyond the 30th, then, she would have had four days? 11:59AM

A. Yes. 11:59AM

Q. So -- one, two, three, four -- down to October the 4th? 11:59AM

A. 4th. 11:59AM

Q. Is that right? 11:59AM

A. Uh-huh. 11:59AM

Q. Okay. And do you get any indication from the notes as to why she is prescribing continued SMZ? 11:59AM 12:00PM

A. The purulent discharge. The interesting thing is that she didn't observe any lameness. You know, that just -- that doesn't fit. But she did see discharge and obviously the wound was still open. Any time you have an open wound, you have horses out in the environment, you worry about infection. 12:00PM 12:00PM 12:00PM 12:00PM 12:00PM 12:00PM

Q. What is purulent? Am I saying that word right? 12:00PM 12:00PM

A. Yeah. Mucopurulent. 12:00PM

Q. What does that mean? 12:00PM

A. That's just a yellow discharge. Purulent is a way of describing that. It can be infectious. 12:00PM 12:00PM

Q. It can be infectious or it can be noninfectious, correct? 12:00PM 12:00PM

A. Uh-huh. 12:00PM

Q. And the only way to know if it's infectious is to culture it, right? 12:00PM 12:00PM

A. Well, typically any time a discharge isn't 12:00PM

clear or serous, you expect it to be, you know, infectious. Something is triggering it to be colored. Or, you know, if it's not bloody, if it's not serous, then yellow would be infectious. 12:00PM

Q. So she would -- a reasonable veterinarian would have assumed seeing a purulent discharge, that it was infectious, right? 12:01PM

A. Yes. And that's probably why she refilled or got a longer course of antibiotic. Like I said, the strange thing is normally if you have a joint injection, it's painful and she didn't notice any lameness. 12:01PM

Q. She said, "NO SIGNIFICANT LAMENESS"? 12:01PM

A. "OBSERVED," uh-huh. 12:01PM

Q. Would the Banamine have anything to do with that? 12:01PM

A. It can decrease inflammation. 12:01PM

Q. Did -- is there any way that Dr. Mosley could have known where the purulent discharge was coming from? And by that I mean was it coming from the joint or somewhere else? 12:01PM

A. I mean, visual exam, just, you know, looking at it. It does look like the owner is still giving oral antibiotics, but had stopped Banamine. So I don't know if that had anything -- you know, weighing in on her thought process. 12:01PM

Q. Back to my question, though. Is there any way that she could have known from looking did the purulent discharge include joint fluid or did it not? 12:01PM 12:02PM 12:02PM

A. No. 12:02PM

Q. In order to know whether the purulent discharge included joint fluid which would tip you off, right? Wouldn't that be a tip-off? 12:02PM 12:02PM 12:02PM

A. Sure. 12:02PM

Q. Then you'd have to do a culture, right? 12:02PM

A. Yeah. Culture would find bacteria. 12:02PM

Q. Or a gram stain? Is that what you'd have to do? 12:02PM 12:02PM

A. Sure. Looking at cytology. Uh-huh. 12:02PM

Q. And what would that tell you? 12:02PM

A. Will tell if you there's bacteria involved. The thing is she saw the discharge there on the outer surface, you know, the outer surface of the wound. 12:02PM 12:02PM 12:02PM

Q. Well, right. The wound was still open? 12:02PM

A. Uh-huh. 12:02PM

Q. But that certainly could have been discharge with joint fluid in it, right? 12:02PM 12:02PM

A. It could have, yes. 12:02PM

Q. And she wouldn't have known one way or the other without doing some cytology, correct? 12:02PM 12:02PM

A. Yes. 12:02PM

Q. And it's no indication in these notes that any cytology was done, right? 12:02PM 12:03PM

A. No. 12:03PM

Q. What's Granulex spray? 12:03PM

A. It's a topical wound healing spray. It allows the body to lay a bed of healthy granulation tissue and kind of helps to -- you know, helps treat the -- any topical debris, you know, help make it a harsh environment for bacteria and it helps the body to formulate a wound healing, if you will. It's commonly used in cuts, scrapes, abrasions, those type of things. 12:03PM 12:03PM 12:03PM 12:03PM 12:03PM 12:03PM 12:03PM 12:03PM

Q. It's not an antibiotic, is it? 12:03PM

A. Not in itself. 12:03PM

Q. Isn't it true that if it were suspected that there were an infection inside the wound, a reasonably prudent veterinarian would be extremely cautious about closing up the wound? 12:03PM 12:03PM 12:03PM 12:03PM

A. Yeah. I mean, yeah, you worry about infection. If you suture the wound closed, it can get worse. 12:03PM 12:03PM 12:04PM

Q. And here there's every indication that there is an infection somewhere inside that wound, correct? 12:04PM 12:04PM

A. Judging from the discharge, yes. 12:04PM

Q. Granulex is intended to close up the wound, isn't it? 12:04PM

A. Well, Granulex is to help heal it. Like you wouldn't put a stitch in to close it. This is a -- not a quick thing. This is a topical spray applied daily. It's not a quick wound heal like a stitch or something. 12:04PM

Q. Okay. 12:04PM

A. Uh-huh. 12:04PM

Q. And she wanted the Granulex on there daily, correct? 12:04PM

A. Yes. 12:04PM

Q. Okay. 12:04PM

A. Cleaning -- yeah, Granulex and bandaging. 12:04PM

Q. Is there any indication in the treatment notes for the 28th that Ms. Santerre was not following the veterinarian's instructions? 12:04PM

A. Nothing is mentioned about her -- nothing at all. 12:04PM

Q. And so the next contact that I see in the patient history report is on October 5th. 12:04PM

Do you see that? 12:04PM

A. Yes. 12:04PM

Q. That is HM. 12:05PM

Is that Dr. Moore? 12:05PM

A. Heidi Moore. Uh-huh. 12:05PM

Q. Okay. And so that's October 5. 12:05PM

That would have been the date after the 12:05PM

SMZ tablets would run -- have run out, correct? 12:05PM

A. Yes. 12:05PM

Q. Okay. And apparently there was a contact at that time. 12:05PM

Do you know from whom to whom? That is, did Ms. Santerre call or do you know? 12:05PM

A. I would suspect because Dr. Moore wasn't even involved. So I would assume, yeah, she called in. Dr. Moore yielded her phone call. 12:05PM

Q. Okay. And she switched from the Granulex to something different, right? 12:05PM

A. Uh-huh. 12:05PM

Q. What did she switch to? 12:05PM

A. Quadritop ointment. It's a topical antibiotic and antiinflammatory. 12:05PM

Q. Quadritop, if I'm not mistaken, is a salve that's used to clear up ear infections and some minor skin infections in cats and dogs, is that right? 12:05PM

A. It can be, uh-huh. 12:05PM

Q. It's certainly not any kind of broad-spectrum antibiotic, right? 12:06PM

A. It's like a triple antibiotic mixed with an antiinflammatory. 12:06PM

Q. It's like Neosporin? 12:06PM

A. Similar. 12:06PM

Q. But it's not -- there's some kind of infection deeper down inside that wound that's not going to touch it, is it? 12:06PM

MR. GOLDSMITH: Objection, form. 12:06PM

Go ahead. You can answer. 12:06PM

THE WITNESS: Huh? 12:06PM

Q. (BY MS. ALLEN) Quadritop is not going to be effective on an infection that's not on the skin? 12:06PM

A. It's treating an outer -- yeah. It's treating topical, an outer surface. 12:06PM

Q. So if there's an infection under the skin or in the joint, Quadritop is not going to be effective, right? 12:06PM

A. Yes. 12:06PM

Q. Do you have any idea what the thought process would be to switch to Quadritop under these circumstances? 12:06PM

A. Maybe -- was this one that maybe an e-mail picture was? I'm not sure. 12:06PM

Q. I don't know. 12:06PM

A. I'm not sure. 12:06PM

Q. We can look at some e-mails if you want. 12:06PM

A. No. I was just wondering maybe she saw the e-mail and thought -- because sometimes we'll use these type of formulations when we're worried that the 12:07PM

granulation tissue is getting too large. I'm just thinking because she hadn't seen the horse, maybe she saw an e-mail. I'm not sure. 12:07PM

(Exhibit 14 marked) 12:07PM

Q. (BY MS. ALLEN) Here we go. 12:07PM

A. Was that on the 5th of October? 12:07PM

Q. Let me show you Exhibit 14. 12:07PM

A. Okay. 12:07PM

Q. And see if that's kind of what you're thinking of. 12:07PM

A. (Reviewing document.) Oh, yeah. She e-mailed it on the 4th. And so I bet she was just responding to the e-mail and her thought was changing the topical -- the topical medication. 12:07PM

Q. Okay. 12:07PM

A. Granulex promotes granulation tissue, hence its name. And that's the pink tissue you see filling in the area. So a topical like Quadritop will likely reduce that region so it's not protruding out. So that could have been her thought behind switching the ointment. 12:07PM

Q. Okay. And it's very clear from Ms. Santerre's e-mail that she's ready to bring the horse to the clinic if the doctors think that that's what she needs to do, right? 12:08PM

A. Yeah. "If you want me (sic) to see him, I can bring him in" in the morning or sooner. Yes. 12:08PM

Q. And is there any indication from the clinic's records that anybody suggested to her that that's what she needed to do? 12:08PM

A. There's nothing commented about their call or anything. 12:08PM

Q. Okay. 12:08PM

A. And I don't think there was a follow up e-mail or -- I don't think. 12:08PM

Q. Okay. And if you look at the -- on Exhibit 14, if you look at the photo and compare it to the leg that's beside it, it -- the leg is clearly swollen, is it not? 12:08PM

A. Yeah, it appears swollen. 12:08PM

Q. And that's not what you would expect to be seeing, is it? 12:08PM

A. I mean, there's going to be inflammation. But definitely it's swollen. 12:09PM

Q. But that's not what you would except to be seeing if the protocol that you were using was working over the course of the last what, couple weeks or more? 12:09PM

A. Two weeks. 12:09PM

Q. Is it? 12:09PM

A. No. 12:09PM

Q. Okay. And then it looks like there is a contact on the 14th with JS? 12:09PM

A. Dr. Schroeder. 12:09PM

Q. Okay. So Dr. Schroeder on the 14th. 12:09PM

And does that appear -- does it appear that Harvey was in the clinic at that time? 12:09PM

A. No. He was just given medication. Owner in lobby. Yeah, owner in lobby, meds for the horse. 12:09PM

Q. Okay. Is there any indication in -- so looks like Dr. Schroeder dispensed some more SMZ? 12:09PM

A. Uh-huh. 12:10PM

Q. Okay. So then that's -- is that four days' worth, 80 tablets? 12:10PM

A. Yes. 80 tablets. 12:10PM

Q. So that would have taken the SMZ from 14, 15, 16, to the 17th or 18th? 12:10PM

A. Yes. 12:10PM

Q. So she would have been out on the 18th? 12:10PM

A. Uh-huh. But then on the 17th, which there still should -- still should have had some or maybe -- it got refilled again back to back. I'm not sure because it's -- there's like two scripts in here on the 17th. So looks like it got refilled again. 12:10PM

Q. Well, let's see. If it had been, it should be on the bill, right? 12:11PM

A. Sure.

Q. So we could look on the bill if we wanted to double-check that to make sure because I'd like to get a handle on what kind of antibiotics she had.

A. Uh-huh.

Q. Let's see if I can find a statement that corresponds to that. There is a statement for the 17th.

Is that when you think it might have been double filled?

A. I think it just might have been a computer glitch probably.

Q. That's what I'm thinking.

A. Yeah.

Q. Because if you look on the invoice, Exhibit 15 --

(Exhibit 15 marked)

A. She got charged for 140. Yeah. It was just a glitch.

Q. (BY MS. ALLEN) So Exhibit 15, you're able to confirm that it was a computer glitch?

A. Uh-huh. So she got another seven days.

Q. Seven?

A. Uh-huh.

Q. Okay. Because we looked and it said 80. Maybe he changed his mind. I looked at the treatment

notes on Page 4 and it said 80 tablets. 12:12PM

A. Yeah. 80 tablets. And then on the 17th there was 140. So I'm not sure. 12:12PM

Q. Well, let's see if we can find an invoice for the 14th. 12:12PM

(Exhibit 16 marked) 12:12PM

Q. (BY MS. ALLEN) All righty. We're getting there. 12:12PM

Exhibit 16 is the invoice from the 14th, right? 12:12PM

A. Uh-huh. 12:12PM

Q. You'll have to say yes or no. 12:12PM

A. Yes. 12:12PM

Q. And it reflects a charge for 80 SMZ? 12:12PM

A. Uh-huh. 12:12PM

Q. So that was on the 14th and that would have gone -- taken her to the 18th, right? 12:12PM

A. Yes. Uh-huh. 12:13PM

Q. And then we saw on the 17th -- 12:13PM

A. She got another seven days. 12:13PM

Q. So -- 12:13PM

A. So that would have gone -- 12:13PM

Q. If she had started that -- 12:13PM

A. -- to the 25th. 12:13PM

Q. Yeah. It would have gone to the 25th. Okay. 12:13PM

Okay. And do you see any indication in the notes that Dr. -- is it Schroeder or Schroeder? 12:13PM

A. Schroeder. 12:13PM

Q. How does he say it? 12:13PM

A. Schroeder. 12:13PM

Q. -- Schroeder required or requested Judy to come and bring the horse in? 12:13PM

A. There's no -- there's nothing in here about their conversation. 12:13PM

Q. Okay. 12:13PM

A. Nothing noted. 12:13PM

Q. And then help me with this. If you look on the 14th -- and I'm looking on Page 3 of the patient history. 12:14PM

A. Uh-huh. 12:14PM

Q. If you look on the 14th, the entry, it says -- in the category that says "Type," what does that mean (indicating)? Do you see command just "Type." 12:14PM

Do you see what that is? 12:14PM

A. Yeah. 12:14PM

Q. Do you know what that means? 12:14PM

A. Honestly, I don't know. Maybe -- maybe B is billing. I'm not sure what that means. I know staff is the provider it goes under. And LA just stands for large animal medication. 12:14PM

Q. Okay.
A. But I don't know what CK or the rest of those are.
Q. Okay. Fair enough.
A. My manager would probably know.
Q. But directly above that bottom one that says CK --
A. Uh-huh.
Q. -- JS, where you see 80 tablets?
A. Uh-huh.
Q. It talks about ten tablets twice a day until gone, right?
A. Uh-huh.
Q. And that's the same thing that you had been giving, correct -- I mean, that the clinic been dispensing --
A. Yeah.
Q. -- through Dr. Mosley or Dr. Moore?
A. Same medication.
Q. Okay. And the same dosage?
A. Yes.
Q. And then above that on the 17th where we saw he did dispense additional medication --
A. Uh-huh.
Q. -- it says ten tablets in the feed once daily.

Now, what would be the reason for backing off on the antibiotics at this point? 12:15PM

A. I'm not sure. 12:15PM

Q. Would there be a reason for backing off on the antibiotics at that point? 12:15PM

A. No. Typically it's a twice-a-day medication. 12:15PM

Q. That's what I've always thought. 12:15PM

A. I thought maybe he messed up the script, but the other script above it says the same. 12:15PM

Q. Right. If we look at the two entries -- 12:15PM

A. Uh-huh. 12:15PM

Q. -- both of them say once daily. And I was wondering what the rationale would be for cutting back on the antibiotics under Harvey's circumstances. 12:15PM

A. I don't know the answer to your question. 12:15PM

Q. Okay. But clearly you can see from the notes that is a cutting back on the antibiotics, right? 12:16PM

A. Uh-huh. Uh-huh. I don't have an answer for that. 12:16PM

Q. Okay. All right. And then on the 8th, it looks like Harvey was brought to the clinic and saw Dr. Mosley, right? 12:16PM

A. Yes. 12:16PM

Q. Okay. So if we go back to Exhibit 13, I just want to get that visit down on November 8th. 12:16PM

Okay. And that is when she took the x-rays? 12:16PM

A. Yes, exam and x-rays. Uh-huh. 12:16PM

Q. Okay. If we flip to the Page 2, we kind of get her narrative -- 12:16PM

A. Sure. 12:16PM

Q. -- or her notes -- 12:16PM

A. Her notes. 12:16PM

Q. -- there. If could you go there with me. She has HX -- 12:16PM

A. History. 12:16PM

Q. -- which is history. And she's noting that on the 8th is "RIGHT FRONT FETLOCK IS SWOLLEN & PAINFUL AGAIN," right? 12:17PM

A. Uh-huh. 12:17PM

Q. And physical exam, I'm taking that, "RIGHT FRONT" -- 12:17PM

A. Physical exam, uh-huh. 12:17PM

Q. -- "FETLOCK SWOLLEN & WARM TO THE TOUCH." Even though he's not necessarily limping, the wound is closed, right? But obviously it's not -- the leg is not healed, isn't that right? 12:17PM

A. This is a strange case. It doesn't make sense why he had no lameness, but it was swollen and it was warm. 12:17PM

Q. At best, then, it was a -- it was kind of inexplicable -- 12:17PM
A. Uh-huh. 12:17PM
Q. -- right? 12:17PM
A. Yes. 12:17PM
Q. And it would have called for more diagnostics in order to figure out what was going on, is that correct? 12:17PM
A. Yes. 12:17PM
Q. Only one thing was done at that point in time by way of diagnostic and that was to take two x-rays, right? 12:18PM
A. Yes. 12:18PM
Q. Okay. She sent him home with some more SMZ, right? 12:18PM
A. Yes. And this says twice a day. 12:18PM
Q. So she went back to twice daily, and on the 8th. So she gave him enough for seven days? 12:18PM
A. Yes. 12:18PM
Q. Okay. So on the 8th he gets enough SMZ to go to the 15th? 12:18PM
A. To the 15th. 12:18PM
Q. So I've marked that on Exhibit 13. 12:18PM
So there was a point in time there where he didn't have the SMZ -- 12:18PM

A. Uh-huh. 12:18PM
Q. -- for about a week -- 12:18PM
A. Uh-huh. 12:18PM
Q. -- correct? Okay. No. 12:18PM
A. No, about two weeks. 12:18PM
Q. Actually, I'm not sure that's right because you and I cal- -- when we calculated the 25th, we calculated it on a twice daily. 12:19PM
A. So -- 12:19PM
Q. She was giving him once daily. 12:19PM
A. So could have gone down to the 1st instead of the 25th. 12:19PM
Q. Right, on a once daily. 12:19PM
A. So either two or three weeks without antibiotics. 12:19PM
Q. Let's see. He started once daily -- 12:19PM
A. On the 25th. 12:19PM
Q. No. He started once daily on the 17th, right? 12:19PM
A. Oh, on the 17th? 12:19PM
Q. 17th, 140 tablets once daily. 12:19PM
A. Uh-huh. 12:19PM
Q. Is that right? 12:19PM
A. Yes. 12:19PM
Q. So that would have gone for 14 days? 12:19PM
A. So down to the 31st (indicating). 12:19PM

Q. Okay. 12:19PM
A. So down there. 12:19PM
Q. So I put it on the 31st then. And -- 12:19PM
A. And on the 8th she got -- she prescribed more antibiotics until the 15th. So he went one week without it. 12:19PM
Q. Okay. Got it. 12:20PM
And then -- so she brought him back in looks like on the 8th, is that right? 12:20PM
A. Uh-huh. Yes. 12:20PM
Q. Is there any explanation in your mind as to why at this point in time there were not further diagnostic procedures taken? 12:20PM
A. I'm not sure. 12:20PM
Q. Can you think of any explanation why at this point in time and under the circumstance that we had there were not further diagnostic steps taken? 12:20PM
A. Maybe based on what she saw on the radiographs and the fact that he wasn't lameness and his temperature was normal, she would like to continue treatment. 12:20PM
Q. Is there any reasonable explanation for what she was observing in the -- in terms of the right front fetlock being swollen and painful again with a closed wound besides an infection in the leg? 12:21PM
A. That's definitely a possibility. You know, 12:21PM

other than that, you know, just local inflammation. But by this time the wound -- the outer wound had healed. 12:21PM

Q. So there's really no explanation other than a joint -- or an infection in the leg somewhere? 12:21PM

A. Sure. 12:21PM

Q. Isn't that right? 12:21PM

A. But the strange thing is, like I said, his temperature was normal too. It doesn't always mean infection, but... 12:21PM

Q. This Divers book -- and we can look at it if we need to, the authoritative treatise that you and I looked at a little bit earlier. 12:21PM

A. Yes. 12:22PM

Q. If we look at the section on joint lacerations, again it says -- I'll just show you mine and not flip a bunch of paper. But it says, "If the patient becomes progressively more lame as the laceration heals, suspect infection." 12:22PM

And that's what was happening, right? 12:22PM

MR. GOLDSMITH: Objection. 12:22PM

Q. (BY MS. ALLEN) It was getting swollen, painful? 12:22PM

A. But he just didn't follow the book because he didn't get more lame. He hadn't -- he didn't have the lameness. So he just didn't follow the textbook case, I 12:22PM

guess. 12:22PM

Q. Okay. He was more mysterious -- 12:22PM

A. Exactly. 12:22PM

Q. -- than the textbook case? 12:22PM

A. Because obviously if they get more lame, sure. It's just strange why he didn't have the lameness then. 12:22PM

Q. Is -- so given that it was more mysterious than the textbook, is there any explanation you can think of as to why the standard of care would require anything less than further diagnostics? 12:22PM 12:23PM

A. I'm not sure. 12:23PM

Q. Okay. Now, Dr. Mosley -- well, let me back up. 12:23PM

Is there, in your mind, any explanation for continuing with the SMZ under circumstances indicating they're clearly not working? 12:23PM

A. I mean, he didn't have any side effects to it. So they continued the antibiotic. It didn't hurt him. You know, I don't know if it was going to progress it or not, but it was an antibiotic. 12:23PM

Q. There are antibiotics that will knock out a joint infection, right? 12:23PM

A. Sure. 12:23PM

Q. SMZ is probably not one of them, is it? 12:23PM

A. It may not be the first choice. 12:23PM

Q. If you have a joint infection or you think you might have a joint infection, what you go to is something like Gentamicin -- or I don't know how you say it. 12:23PM 12:23PM 12:24PM 12:24PM

A. Yeah, penicillin, Gentamicin. 12:24PM

Q. Amicus -- Amikacin. I don't know how to say that. 12:24PM 12:24PM

A. Yeah. Sure. 12:24PM

Q. You go to something else if you suspect that you might have a joint infection. 12:24PM 12:24PM

Isn't that the protocol? 12:24PM

A. Yes. 12:24PM

Q. And that was not done here, right? 12:24PM

A. No. 12:24PM

Q. Okay. And then her note on the radiographs, if you just flip over to Page 3, she saw, according to her notes, "SIGNIFICANT SOFT TISSUE SWELLING"? 12:24PM 12:24PM 12:24PM

A. Uh-huh. 12:24PM

Q. I don't know what osteophyte production is. Help with us that. 12:24PM 12:24PM

A. That's like mild bony growth. 12:24PM

Q. Bony changes? 12:24PM

A. Mild. Like osteophyte is just a growth. Along the lateral aspect, that's the outer aspect. 12:24PM 12:24PM

Q. What does that tell you? 12:24PM

A. Any type of impact or -- necessarily like any type of trauma could hit -- even that issue the bone -- when the bone heals, it can form an osteophyte. The thing we typically look for with infection is lysis, which is bone not growing, but getting worn out, if you will. 12:24PM 12:24PM 12:25PM 12:25PM 12:25PM 12:25PM

Q. Understood. 12:25PM

A. Uh-huh. 12:25PM

Q. And then "NARROWED JOINT SPACE." And you and I talked about that a little while ago, that that was one was indicators of a joint infection, correct? 12:25PM 12:25PM

A. It can be. Can be a positional change. It could be, you know, from pressure from the swelling. There are different things you can see. 12:25PM 12:25PM

Q. But one of the things that it can be is indicative of a joint infection, correct? 12:25PM 12:25PM

A. It can. 12:25PM

Q. And then it says, "OSSIFICATION" -- am I saying that right? 12:25PM 12:25PM

A. Uh-huh. 12:25PM

Q. -- "OF COLLATERAL CARTILAGE OF P3." 12:25PM

What is that? 12:25PM

A. That's the -- the coffin bone. That isn't even related to this region. 12:25PM 12:25PM

Q. But what does it mean? 12:25PM

Hurd, Kate

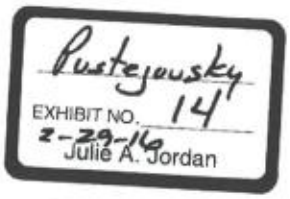
From: Bastrop Veterinary Hospital BVH <bastropvet@hotmail.com>
Sent: Tuesday, December 08, 2015 1:45 PM
To: Jim Goldsmith
Subject: Fw: Fwd:
Attachments: photo.JPG

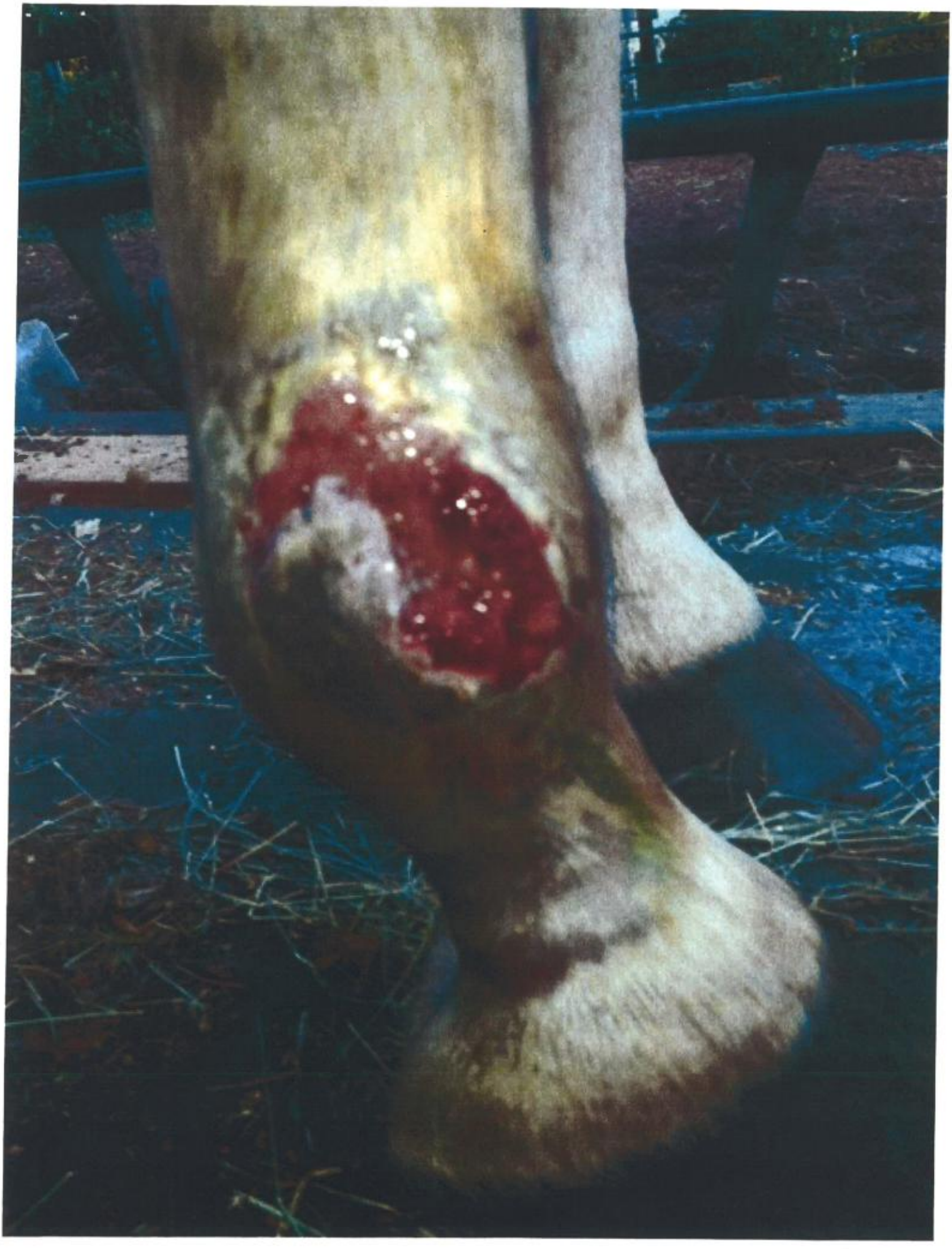
Forwarded email per request on 12/8.
Janet Fitzsimon-Barr, Practice Manager
Bastrop Vet Hospital
512-321-5386

From: J Santerre <jtex363@gmail.com>
Sent: Friday, October 4, 2013 9:29 AM
To: bastropvet@hotmail.com
Subject: Fwd:

Drs.,
Attached is a photo of Harvey's injury. I don't know if this is where he is supposed to be or not. I've been lucky enough to never have to deal with an injury this severe. I am concerned that this wound is still so open. I gave him the last of his antibioltic this morning. Yesterday, he didn't eat with the usual vigor and I took his temperature but it was normal (just above 100). He ate better last night and this morning. He's pooping and drinking water normally. I am hydroing for 10 minutes every night and changing his bandage, using the Granulex. He doesn't limp or appear to be in pain, except at the wound site. It just looks awful. If you want to see him, I can bring him in tomorrow morning (or sooner if you think it's serious).
Judy

---------- Forwarded message ----------
From: **Judy** <jtex363@gmail.com>
Date: Fri, Oct 4, 2013 at 8:44 AM
Subject:
To: Jtex363@gmail.com





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JUDY SANTERRE
836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Client ID: 3605382
Invoice #: 1010671
Date: 10/17/2013

Patient ID: 32301	Species: Equine	Weight:	
Patient Name: HARVEY	Breed: Quarter Horse, American	Birthday: 03/16/2003	Sex: Gelding

	Description	Staff Name	Quantity	Total
10/17/2013	SMZ-TMP 960	Jeffrey Schroeder, DVM	140.00	$42.25
			Patient Subtotal:	**$42.25**

Reminder

04/16/2010	FLU-RHINO
	STREP/STRANGLES VACCINE
	STREP VACCINE INTERVET (use on P.O
04/28/2013	DIGITAL COGGINS TEST
	Fecal Exam
03/16/2014	DEWORM/TUBE/EQUINE
	WEST NILE VACCINE
04/20/2014	RABIES - EQUINE
09/21/2014	TETANUS TOXOID

Invoice Total:	**$42.25**
Total:	$42.25
Invoice Balance Due:	$42.25
VISA/M.C./Discover:	($42.25)
Less Payment:	($42.25)
Invoice Balance Due:	**$0.00**
Balance Due:	**$0.00**

Prestejovsky
EXHIBIT NO. 15
2-25-16
Julie A. Jordan

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Bastrop Veterinary Hospital
www.bastropvet.com
PO Box 625
Bastrop, TX 78602
(512) 321-5386

JUDY SANTERRE
836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Client ID: 3605382
Invoice #: 1010435
Date: 10/14/2013

Patient ID: 32301	Species: Equine	Weight:	
Patient Name: HARVEY	Breed: Quarter Horse, American	Birthday: 03/16/2003	Sex: Gelding

	Description	Staff Name	Quantity	Total
10/14/2013	SMZ-TMP 960	Jeffrey Schroeder, DVM	80.00	$35.05
	COMBINE ROLL		2.00	$6.00
			Patient Subtotal:	**$41.05**

Reminder

04/16/2010	FLU-RHINO
	STREP/STRANGLES VACCINE
	STREP VACCINE INTERVET (use on P.O
04/28/2013	DIGITAL COGGINS TEST
	Fecal Exam
03/16/2014	DEWORM/TUBE/EQUINE
	WEST NILE VACCINE
04/20/2014	RABIES - EQUINE
09/21/2014	TETANUS TOXOID

Invoice Total:	**$41.05**
Total:	$41.05
Invoice Balance Due:	$41.05
VISA/M.C./Discover:	($41.05)
Less Payment:	($41.05)
Invoice Balance Due:	**$0.00**
Balance Due:	**$0.00**

Rustojousky
EXHIBIT NO. 16
2-29-16
Julie A. Jordan

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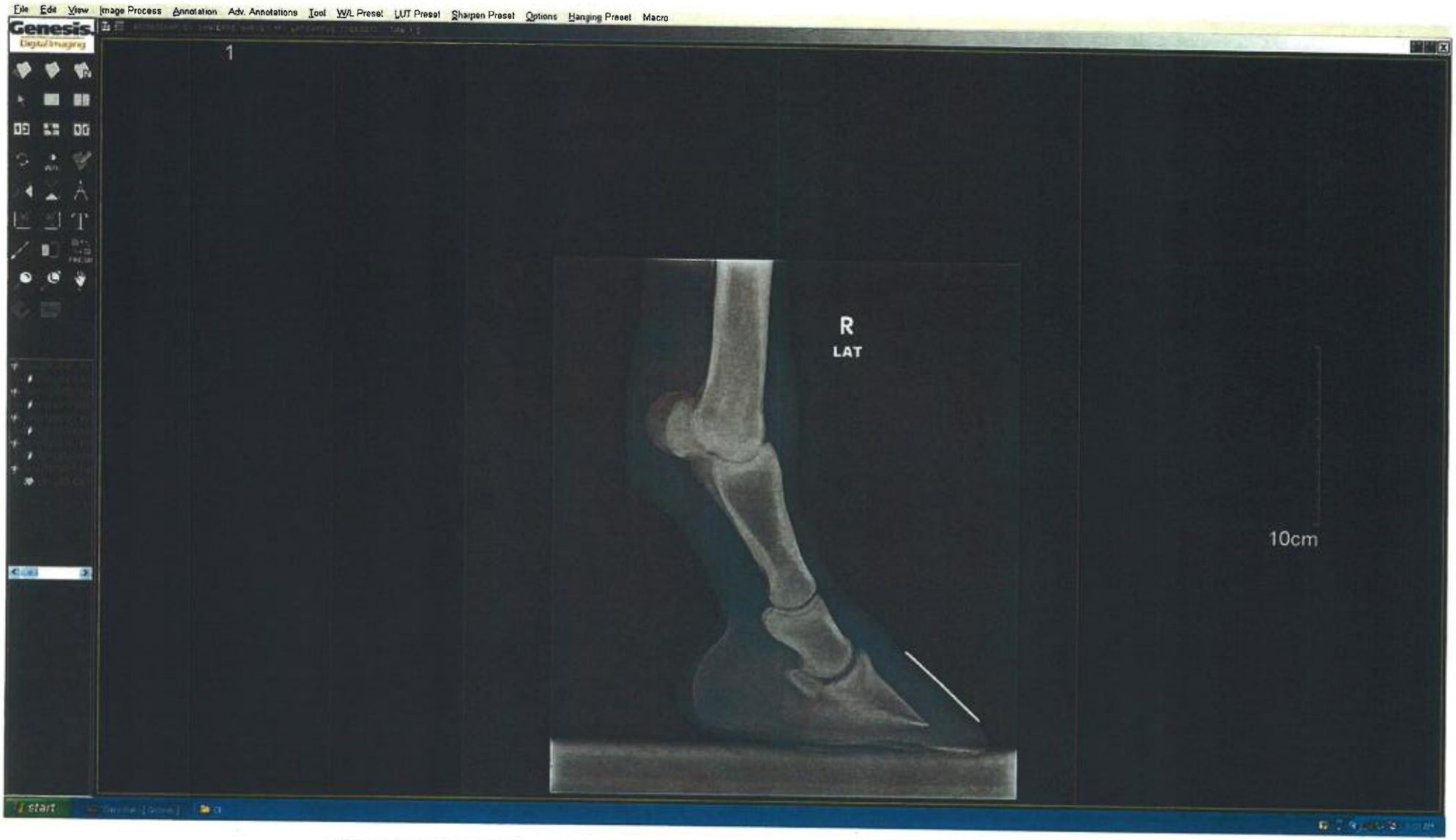
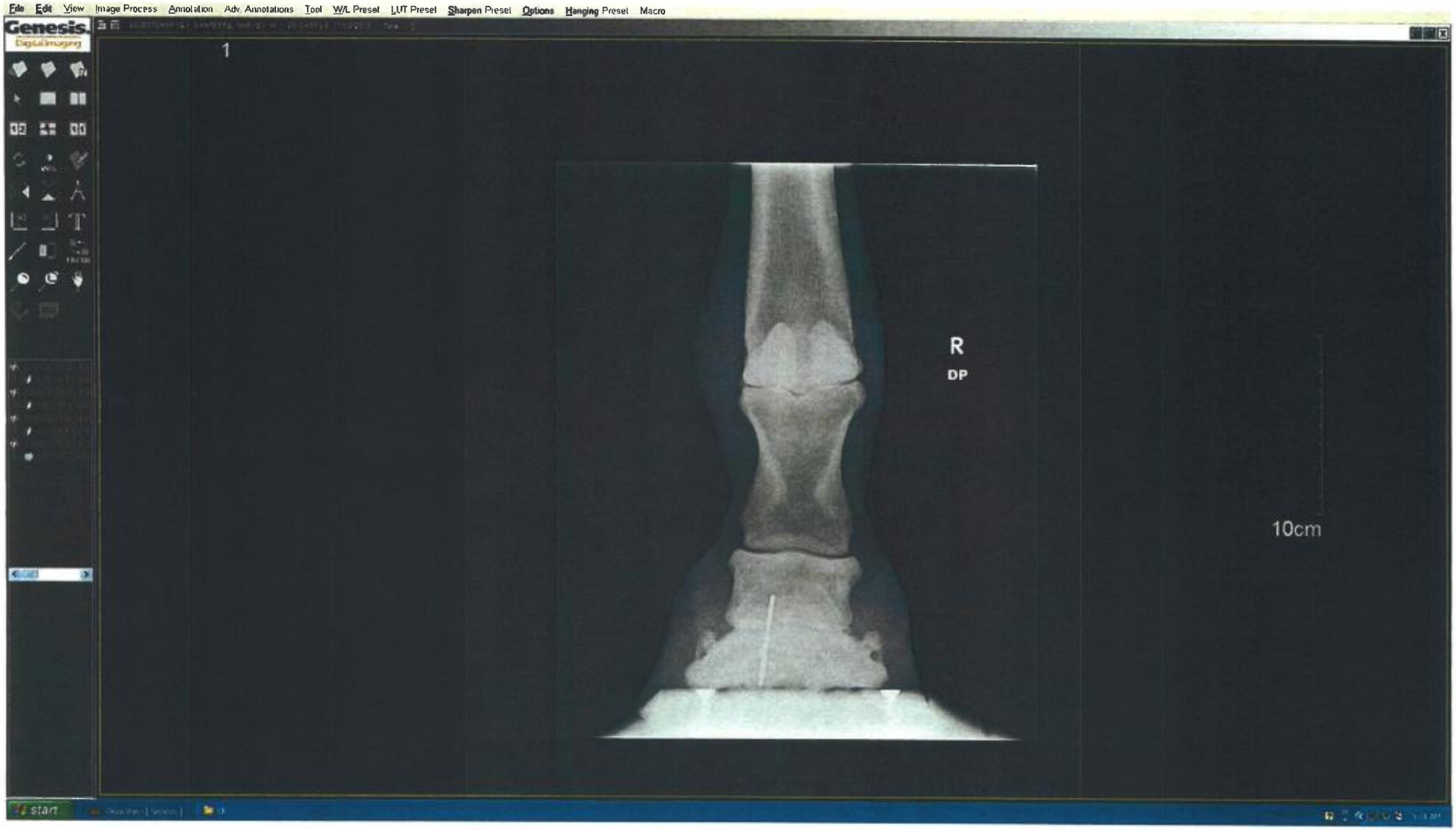


Rustejousky
EXHIBIT NO. 17
2-29-16
Julie A. Jordan



Pustejovsky
EXHIBIT NO. 18
2-29-16
Julie A. Jordan

Bastrop Veterinary Hospital
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Bastrop, TX 78602
(512) 321-5386

JUDY SANTERRE
836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Client ID: 3605382
Invoice #: 1011682
Date: 11/8/2013

Patient ID: 32301	Species: Equine	Weight:	
Patient Name: HARVEY	Breed: Quarter Horse, American	Birthday: 03/16/2003	Sex: Gelding

	Description	Staff Name	Quantity	Total
11/8/2013	EXAM/EQUINE BRIEF	Stefanie Mosley, DVM	1.00	$32.00
	X-RAY EQUINE/PER VIEW		2.00	$93.50
	SMZ-TMP 960		140.00	$42.25
	COMMENT		1.00	$0.00
	THANK YOU! DR. MOSLEY		1.00	$0.00
			Patient Subtotal:	**$167.75**

Instructions

GIVE 1 SCOOP OF BUTE POWDER TWICE DAILY FOR 5-7 DAYS AS NEEDED FOR PAIN & INFLAMMATION.

Reminder

04/16/2010	FLU-RHINO
	STREP/STRANGLES VACCINE
	STREP VACCINE INTERVET (use on P.O
04/28/2013	DIGITAL COGGINS TEST
	Fecal Exam
03/16/2014	DEWORM/TUBE/EQUINE
	WEST NILE VACCINE
04/20/2014	RABIES - EQUINE
09/21/2014	TETANUS TOXOID

Invoice Total:	**$167.75**
Total:	$167.75
Invoice Balance Due:	$167.75
VISA/M.C./Discover:	($167.75)
Less Payment:	($167.75)
Invoice Balance Due:	**$0.00**
Balance Due:	**$0.00**

Rustejousky 19
EXHIBIT NO.
2-29-16
Julie A. Jordan

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A. Ossification, just the cartilage is hardened and the cal -- you see calcium deposit. It's in actually the -- P3 is in your hoof. So it's just a finding she noted. It's not related to this -- this area. 12:25PM 12:25PM 12:25PM 12:25PM 12:26PM

Q. And I think I've got the radiographs. I'm going to mark them. They were produced by the clinic. I know you didn't take them. 12:26PM 12:26PM 12:26PM

A. Uh-huh. 12:26PM

(Exhibits 17 and 18 marked) 12:26PM

Q. (BY MS. ALLEN) I'll mark them as 17 and 18 and let you have a look at them. 12:26PM 12:26PM

A. (Reviewing documents.) 12:26PM

Q. Do you recognize these as the radiographs that were taken at the clinic and that you later looked at, not on the 8th, but later? 12:27PM 12:27PM

A. I believe so. 12:27PM

Q. And do you see the significant soft tissue swelling? 12:27PM 12:27PM

A. Yes. 12:27PM

Q. Where do you see it? 12:27PM

A. Along the lateral margin. 12:27PM

Q. What exhibit number are you on, Doctor? 12:27PM

A. 18. But you can see it on both, 17 and 18. 12:27PM

Q. Okay. And then can you point it out for me? 12:27PM

A. Along the lateral aspect and you can kind of see it on the cranial and caudal aspect. 12:27PM

Q. And what would account for that significant soft tissue swelling? 12:27PM

A. It's a sign of local inflammation. 12:27PM

Q. Well, if we don't think he's been reinjured -- and we don't, right? 12:28PM

A. No, because his outer wound is healed. 12:28PM

Q. Right. He's not had another trauma. 12:28PM

So what does that indicate to you? 12:28PM

A. Likely some type of inflammation or infection. 12:28PM

Q. What would cause the inflammation besides an infection? 12:28PM

A. There's going to be scar tissue there. You know, you could see inflammation around that, you know, along that region. 12:28PM

Q. Is it your belief that scar tissue is going to cause the kind of swelling and inflammation that's described in these notes? 12:28PM

A. No. Usually -- usually it's not as severe. You're not going to see that much inflammation. 12:28PM

Q. But an infection would cause that kind of swelling and inflammation that you see described in these notes, right? 12:28PM

A. Yes, it could. 12:28PM

Q. Okay. And then do you see the narrowed joint space that Dr. Mosley described? 12:28PM 12:29PM

A. Yeah. I can note it here on the lateral view. 12:29PM

Q. And that's Exhibit 19? 12:29PM

A. 17. 12:29PM

Q. 17. Sorry. 12:29PM

A. Uh-huh. 12:29PM

Q. I'm not an upside-down reader. 12:29PM

A. Oh, that's okay. 12:29PM

Q. And could you point out where you see it? 12:29PM

A. Looking along the joint space (indicating). 12:29PM

Q. And so that is -- 12:29PM

A. And we see it mildly -- you can see it on the other view too (indicating). 12:29PM

Q. So if we look back at our fetlock diagram, Exhibit 5, where would we be seeing the narrowing? 12:29PM

A. Like right along this region. 12:29PM

Q. Right in between the bones where there is an arrow that says "articular cartilage"? 12:29PM

A. Yes. 12:29PM

Q. Okay. Is there anything that a narrowing of the joint space would indicate under the circumstances that Harvey presents at this time, that is the time of these radiographs, other than a joint infection? 12:29PM

A. Joint infection or traumatic injury. 12:29PM

Q. We know he didn't have the traumatic injury. 12:30PM
A. Other than the first one. 12:30PM
Q. But that's healed, right? 12:30PM
A. Yes. 12:30PM
Q. Okay. And when you looked at these x-rays sometime later -- 12:30PM
A. Uh-huh. 12:30PM
Q. -- you saw those same things that you just didn't consider them significant? 12:30PM
A. Yes, ma'am. 12:30PM
Q. Looks like Dr. Mosley prescribed Bute powder for pain and inflammation, is that right? 12:30PM
A. Yes. 12:30PM
Q. What is Bute powder? 12:30PM
A. Bute is a nonsteroidal antiinflammatory similar to Banamine. 12:31PM
Q. You said "nonsteroidal" -- 12:31PM
A. Antiinflammatory. 12:31PM
Q. -- "antiinflammatory"? 12:31PM
A. Sorry. It's similar to Banamine except for it's in oral form and it's used to commonly for lameness, musculoskeletal disorders. 12:31PM
Q. And is the one scoop of Bute powder twice daily for five to seven days as needed, is that the proper dosage? 12:31PM

A. It ranges. One scoop is equal to one gram. And typically you can -- you can go up to a total of four grams a day, depending on the level of pain and inflammation is the dosage. You know, you do a range of five -- one gram to four grams. Excuse me. 12:31PM

Q. And with the use -- with the administration of one gram of Bute twice a day for five to seven days, unless there were other complications, you'd expect to be seeing a marked improvement, would you not? 12:31PM 12:32PM

A. Sure. Should be less painful. 12:32PM

Q. And then it looks like on the -- if I'm -- I'm looking back at the patient history -- that on the 18th large animal dispense had some Bute paste, right? 12:32PM 12:32PM

A. Yes. So paste is the same as -- it's the same medication. Instead of being in a powder formula, you just paste them with it. 12:32PM 12:32PM

Q. And so the Bute that she left the clinic with -- that Judy Santerre left the clinic with on the 8th, how long would that have lasted her? 12:32PM 12:32PM

A. I'm not sure what size. I can't find on here what size it would be. I don't see on here. Do you see where we sold it, where it says how many -- how big the jar and how many grams? 12:32PM 12:33PM 12:33PM

Q. I didn't see it, but I thought -- 12:33PM

A. Me neither. 12:33PM

Q. -- there was a code here that might tell you. 12:33PM

A. I'm not sure. I would say it at least had 25 grams. Some -- some jars have 50, which would be 50 scoops or 25 scoops. I would say at least 25 scoops. 12:33PM

Q. And that would be twice a day, so that would be -- 12:33PM

A. So, yeah, at least 12 days. But then she came and got a paste. So maybe the -- maybe the powder wasn't working or she used it up. 12:33PM

Q. Well, it's interesting because there's no Bute powder on her bill. Let's just look at the statement for the 8th. 12:33PM

A. So she may not have gotten it. 12:33PM

(Exhibit 19 marked) 12:33PM

Q. (BY MS. ALLEN) Do you see on Exhibit 19, which is the statement for the visit on the 8th -- 12:34PM

A. Huh-uh. 12:34PM

Q. -- do you see that the clinic actually dispensed any Bute powder to her? 12:34PM

A. No. But it's strange that there is a label. So I'm not sure. Or -- or whatever this was. 12:34PM

Q. So it might have sent her home without any Bute? 12:34PM

A. Yeah. 12:34PM

Q. Just don't know? 12:34PM

A. It says, "USE BUTE A FEW MORE DAYS AS NEEDED FOR PAIN." Not unless he -- oh, maybe "I" means invoice. So this may have just printed out for her and she was to use some medicine she had at home. Some owners keep Bute or Banamine at home. 12:34PM

Q. Okay. So you're just not -- 12:34PM

A. Maybe. I'm not sure. But from what I can see, I think "I" might stand for -- we can type a message into their invoice and this may have been her directions on the invoice of -- oh, yeah. Yeah. Here we go. So instructions. That's what "I" stands for is instructions. 12:34PM 12:35PM

Q. We'll get to the bottom of this. 12:35PM

A. Yeah. Sooner or later. And so that's probably she had it at home. 12:35PM

Q. Okay. 12:35PM

A. So she didn't pick up any more. 12:35PM

Q. Not sure then? 12:35PM

A. We don't know how much she had, but we know she had it. 12:35PM

Q. Okay. 12:35PM

A. And she -- you know, she may have been using that in combination with Banamine this whole time. It just wasn't delegated. 12:35PM

Q. Okay. Fair enough. 12:35PM

And so then it does look like on the 18th, so she's given -- 12:35PM

A. She got the paste form. Uh-huh. 12:35PM

Q. And that's the same medication, but in a paste? 12:35PM

A. In a paste. Uh-huh. 12:35PM

Q. And is there an indication of what the dosage that is prescribed is? 12:35PM

A. I mean, I don't see the label on here. And so the paste is -- so the powder is a scoop or is the paste -- each gram is a click on the -- on the dial. 12:35PM

Q. Right. 12:35PM

But can you tell how much she was supposed to be giving of this paste? 12:35PM

A. I don't see anything notated here. 12:36PM

Q. And large animal, I'm taking it, wouldn't dispense a medication like Bute paste without a doctor authorizing it, right? 12:36PM

A. No. 12:36PM

Q. I mean, you couldn't just walk up and buy that over the counter, could you? 12:36PM

A. No. No. 12:36PM

Q. Can you tell who authorized that -- 12:36PM

A. It doesn't -- 12:36PM

Q. -- in this instance? 12:36PM

A. It doesn't say. I mean, large animal is just a term that they -- 12:36PM

Q. Right. No, I get that. 12:36PM

A. Yeah. 12:36PM

Q. Large animal is the dispenser of these things, but large animal has to be instructed by somebody -- 12:36PM

A. On what to do. 12:36PM

Q. -- in a position of authority to do it, correct? 12:36PM

A. Uh-huh. Uh-huh. 12:36PM

Q. Okay. You just can't tell from this record who that was -- 12:36PM

A. Exactly. 12:36PM

Q. -- is that right? Okay. 12:36PM

A. Uh-huh. 12:36PM

Q. Then on the 26th it looks like Dr. Weiss dispensed some more Banamine, right? 12:36PM

A. Uh-huh. 12:36PM

Q. Okay. And so the 26th of November we got Dr. Weiss dispensing some Banamine. 12:36PM

Have I got that right on Exhibit 13? 12:37PM

A. 26th. Uh-huh. 12:37PM

Q. Okay. And is there -- and he says 10 cc's once a day for pain and inflammation, right? 12:37PM

A. Uh-huh. 12:37PM

been treating this horse for so long already, and I know I was new to the case, but that I needed to refer to an orthopedic specialist. This was on a Friday, I believe. And so I didn't start anything new medicinewise. I mean, he's been on SMZs this whole time. I wanted him on the antiinflammatory Bute instead of Banamine. And her instructions were then to call Monday so we could set up the referral. 12:40PM

Q. Okay. 12:40PM

A. That's the best guess. I can't remember it. 12:40PM

Q. You're -- and this is only place I've seen this in these records, "DDX." 12:40PM

Is that diagnosis? 12:40PM

A. That's my differential diagnosis. Uh-huh. 12:40PM

Q. Okay. I have not -- I didn't see that in any of these other treatment notes. Did you? 12:40PM

A. I mean, that's how I write my notes. That's like my assessment. 12:40PM

Q. And your assessment was "SEVERE INFLAMMATION, POSSIBLE JOINT AND TENDON SHEATH INVOLVEMENT, correct? 12:41PM

A. Yes. 12:41PM

Q. Okay. And you ordered sweat wrap. 12:41PM

Did you put that on? 12:41PM

A. Yes, I applied it. So what I do is I mix a Nitrofurazone, strong antibiotic, mixed with DMSO -- 12:41PM

Q. So would you be giving Banamine and Bute both together in the same day? 12:37PM

A. No. You usually do one or the other. 12:37PM

Q. Is there any indication in these notes that Ms. Santerre was advised to do one or the other? 12:37PM

A. I mean, nothing was noted about their conversation on here. But you don't want to give both together. You worry about affecting the kidneys. 12:37PM

Q. Right. Okay. 12:37PM

Is there any indication here what prompted Dr. Weiss to dispense some Banamine on the 26th? 12:37PM

A. It doesn't say. 12:37PM

Q. Okay. Now, then we come to the visit on the 29th, and that's you? 12:37PM

A. Yeah. 12:38PM

Q. Tell us what you can remember -- you're welcome to look at these notes if you want to. 12:38PM

A. Uh-huh. 12:38PM

Q. But I'd like to know what you can recall about that visit. 12:38PM

A. I mean, I have to rely on my notes because it's been so long ago. 12:38PM

Q. I understand. And that's why I wanted to make them available to you. 12:38PM

A. Sure. Sure. It looks like the wound was 12:38PM

healed on the outside. She had been given Banamine. He still seemed painful. She had been bandaging. I noted three out of five lame. So before -- before he wasn't lame, now he showed up lame. Worse when he first started off. The wound was just scarred. Moderate swelling lateral aspect of fetlock. And this time it was extending up the caudal tendons and down towards the foot. He seemed painful. Decreased flexion and extension of the joint. And carpus just means, you know, up higher. So when I say "carpus," I talk about the joint above it --

Q. Okay.

A. -- was within normal limits.

Q. Was what? I'm sorry?

A. When I -- when I said, "CARPUS UP," I just mean -- "WNL" just means within normal limits. So up above it, that joint felt fine.

Q. Okay. But the fetlock joint did not feel fine?

A. No. No. Decreased flexion, extension painful. "SEVERE INFLAMMATION, POSSIBLE JOINT AND TENDON SHEATH INVOLVEMENT." I think I was more worried now because the swelling had spread. And I know it doesn't note it her in my notes, but if I recall right, at that time, you know, I told her -- I mean, we had

it's a strong antiinflammatory -- to put along the whole area of swelling. I placed it on that day. And, you know, with this sweat wrap, you don't ever leave it on longer than 12 to 24 hours. So I instructed her to remove it tomorrow and then leave the bandages off. That was just a quick, you know, we're going to try pull out swelling to make him a little more comfortable until we referred him. 12:41PM

Q. You were not -- you said Nitrofurazone is a strong antibiotic? 12:41PM

A. Yes. 12:41PM

Q. It's a topical antibiotic? 12:41PM

A. Topical that you mix with -- I mix with -- DMSO is an antiinflammatory. It's just to make it into like a poultice, if you will. 12:41PM 12:42PM

Q. Right. But you certainly weren't trying to treat a joint infection with a Furazone DSMO sweat? 12:42PM

A. No. I was trying to just pull out the swelling around that region. 12:42PM

Q. And you instructed Judy to put him out in a paddock, start back on Bute -- 12:42PM

A. Start back on -- yeah. So I think he had been on Banamine, yeah. And so I had her stop that and start back on Bute. 12:42PM

Q. And it says here, "CALL IF NOT IMPROVING." 12:42PM

A. Uh-huh. 12:42PM

Q. There's nothing here about a specialist or referring to a specialist. 12:42PM

A. Yeah. I didn't put it in my notation, but for -- I mean, I didn't even prescribe any new antibiotic. My only -- all I can remember is talking to her about, you know, We need to get this horse somewhere to a specialist, whether it had been Elgin or A&M. You know, I didn't send her on emergency that day. 12:42PM 12:42PM 12:42PM 12:42PM 12:42PM 12:43PM

Q. Why not? 12:43PM

A. I guess going on two -- two -- however many months already, I was just trying to make him comfortable with the pain medicine until we got him an appointment the next week. 12:43PM 12:43PM 12:43PM 12:43PM

Q. But you thought he had a joint infection, didn't you? 12:43PM 12:43PM

A. Yeah. It was definitely a high possibility. 12:43PM

Q. And that's a 24-hour emergency, right? 12:43PM

A. It can be. 12:43PM

Q. Well, it is, isn't it? 12:43PM

A. Uh-huh. 12:43PM

Q. That's a yes? 12:43PM

A. Yes. It's just he -- and like we talked the whole time, his temperature was normal. I didn't feel any heat. He just didn't fit a hundred percent classic, 12:43PM 12:43PM 12:43PM

you know, as a joint infection. 12:43PM

Q. But honestly, wouldn't that make it all the more important to do the diagnostics to figure out what -- 12:43PM 12:44PM

A. To rule it out. 12:44PM

Q. -- you're dealing with? 12:44PM

A. Sure. 12:44PM

Q. And from looking at the treatment notes and having you explain to us that visit, it does not appear that any of the diagnostics that were called for were done, is that right? 12:44PM

A. They were not. 12:44PM

Q. And the invoice -- let me find that one for you in case it jogs your memory. 12:44PM

(Exhibit 20 marked) 12:44PM

Q. (BY MS. ALLEN) Let me see. First here is -- Exhibit 20 is a photo on the 27th of November, which would be before you saw him. 12:44PM

A. Two days. 12:44PM

Q. But is that about what he looked like when you saw him? 12:44PM

A. Yeah. The swelling is there. 12:44PM

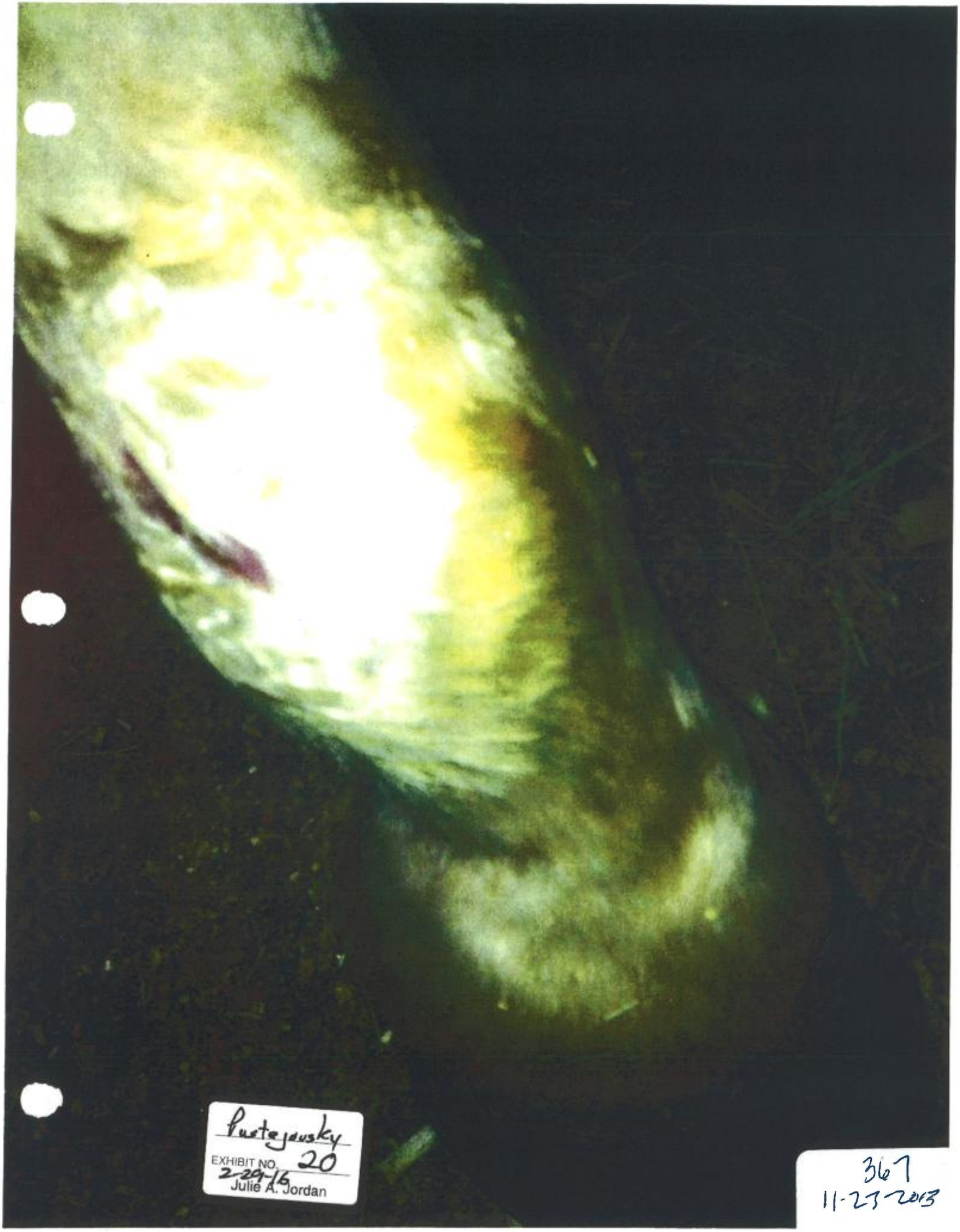
Q. The wound is closed, right? 12:45PM

A. Yes. 12:45PM

Q. So it's not oozing or anything like that? 12:45PM

A. No, no, no. 12:45PM
Q. Everything is inside and it's all swollen, right? 12:45PM
A. Uh-huh. 12:45PM
Q. You'll have to say yes or no? 12:45PM
A. Yes. Sorry. 12:45PM
Q. Thank you. 12:45PM
(Exhibit 21 marked) 12:45PM
Q. (BY MS. ALLEN) Then here is Exhibit 21, which is the invoice from the visit on the 29th, right? 12:45PM
A. Yes. She had been on -- so Phenylbutazone is still -- Bute is still the same medication. This is just a different formulation. It's a tablet form. 12:45PM
Q. Okay. You didn't put him on any antibiotics? 12:45PM
A. I did not. 12:45PM
Q. But he had an infection? 12:45PM
A. He had been on SMZ so many times I didn't refill it. And for some reason I'm thinking if I didn't switch him to injectables, there had to have been a reason. You know, I don't know if the owner was able to give IVs. I'm not sure. I guess we could have kept him in the hospital to give IVs -- IV medication. But in my mind set, I don't know -- I didn't put it in my notes, but referral was, you know, where I was going for him. 12:46PM
Q. Well, what the bill says -- what the notes say 12:46PM

FALSE



Rustejousky
EXHIBIT NO. 20
2-29-16
Julie A. Jordan

367
11-27-2013

Bastrop Veterinary Hospital
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JUDY SANTERRE
836 COTTEL TOWN RD
SMITHVILLE, TX 78957

Client ID: 3605382
Invoice #: 1012691
Date: 11/29/2013

Patient ID: 32301 | Species: Equine | Weight:
Patient Name: HARVEY | Breed: Quarter Horse, American | Birthday: 03/16/2003 | Sex: Gelding

	Description	Staff Name	Quantity	Total
11/29/2013	EXAM/EQUINE BRIEF	Lucy Pustejovsky, DVM	1.00	$32.00
	BANDAGE/SWEAT		1.00	$37.50
	PHENYLBUTAZONE 1GR. TAB		40.00	$23.45
	THANK YOU! DR. PUSTEJOVSKY		1.00	$0.00
			Patient Subtotal:	**$92.95**

Instructions

REMOVE SWEAT WRAP TOMORROW, THEN NO MORE BANDAGING JUST HYDROTHERAPY. YOU CAN LET HIM OUT INTO A SMALL PADDOCK TO GET HIM MOVING AROUND. GIVE BUTE AS NEEDED. PLEASE CALL IF HE DOES NOT IMPROVE WITH TREATMENT.

Reminder

04/16/2010	FLU-RHINO
	STREP/STRANGLES VACCINE
	STREP VACCINE INTERVET (use on P.O
04/28/2013	DIGITAL COGGINS TEST
	Fecal Exam
03/16/2014	DEWORM/TUBE/EQUINE
	WEST NILE VACCINE
04/20/2014	RABIES - EQUINE
09/21/2014	TETANUS TOXOID

Invoice Total:	**$92.95**
Total:	$92.95
Invoice Balance Due:	$92.95
VISA/M.C./Discover:	($92.95)
Less Payment:	($92.95)
Invoice Balance Due:	**$0.00**
Balance Due:	**$0.00**

Pustejovsky
EXHIBIT NO. 21
2-26-16
Julie A. Jordan

Our doctors and staff thank you for choosing our Hospital. We appreciate your business and enjoy providing care for your pets. Be sure to like us on Facebook. Thank You.

and what the bill says is basically call if he does not improve with treatment? 12:46PM

A. Uh-huh. 12:46PM

Q. There's nothing in your notes and there's nothing on the invoice about a referral on the 29th, right? 12:46PM

A. Yeah, I didn't write it in there. 12:46PM

Q. Okay. And then Judy is the one who did call again, right? 12:46PM

A. Yeah. She called on Monday, I believe. It would have been the 2nd. And I wrote down the -- just made -- this is just a quick text on what we talked about. 12:46PM 12:47PM 12:47PM 12:47PM

Q. And where do you find that? 12:47PM

A. It's -- you know, it's out of order. So -- 12:47PM

Q. But on Page 2 at the very top -- 12:47PM

A. Uh-huh. 12:47PM

Q. -- "O CALLED," that's owner called? 12:47PM

A. Owner, yeah. Sorry. 12:47PM

Q. Not getting better, still lame? 12:47PM

A. Yeah. 12:47PM

Q. And that's when -- on the 2nd is when you recommended the referral to the orthopedist -- 12:47PM 12:47PM

A. Uh-huh. 12:47PM

Q. -- at A&M, right? 12:47PM

A. Uh-huh. But I -- I know I prepared her for it. With me not starting more medications, I know -- I mean, I know it's not on here and you're -- it's my word over not being on here, obviously, but I know I told her, you know, that's what we need to do. I mean, we've been treating this horse for this long. I know it was the first time that I might have seen him, but he needed to go to the orthopedic specialist. With it being a, you know, Friday, I probably said, you know, We'll go Monday or call me Monday or -- because it looks like she called Monday. It's just not in my notation. 12:47PM 12:47PM 12:47PM 12:47PM 12:47PM 12:47PM 12:48PM 12:48PM 12:48PM 12:48PM

Q. Okay. But there's no doubt in your mind that Judy Santerre called on Monday -- 12:48PM 12:48PM

A. Yeah. 12:48PM

Q. -- and said, He's not better? 12:48PM

A. She called. 12:48PM

Q. And -- 12:48PM

A. And that's what I probably told her, Just like we talked, we've got to get you set up. We'll send your records over, your x-rays or whatever, you know, get you to -- you know, wherever she wanted to go. But A&M and Elgin are the two closest ones to us that have an orthopedic specialist. 12:48PM 12:48PM 12:48PM 12:48PM 12:48PM 12:48PM

Q. And then from looking at the patient history, it looks like 12/11, "REFERRED TO DR. WATTS." I'm 12:48PM

looking on Page 1. 12:48PM

A. This probably was whenever Dr. Watts called me with an update, because I'm sure she went way before the 11th. That's one nice thing A&M does is they call you with updates. 12:48PM 12:48PM 12:48PM 12:49PM

Q. Okay. So -- 12:49PM

A. They'll let you know how the horse is doing. 12:49PM

Q. You saw him on the 29th. She called you back on the 2nd. We can see from your notes you told her that -- 12:49PM 12:49PM 12:49PM

A. Referral. 12:49PM

Q. -- you were going to refer him. 12:49PM

A. Yeah. 12:49PM

Q. And so do you know what day he went? 12:49PM

A. I'm not sure. I just -- I think this is when I -- when Dr. Watts called me and let me know what was going on with the case. 12:49PM 12:49PM 12:49PM

Q. Was there ever a point in time when you told Ms. Santerre this was an equine emergency, this was -- 12:49PM 12:49PM

A. No. 12:49PM

Q. Was there ever point in a time where you told her, This is something that needs treatment in 24 hours? 12:49PM 12:49PM

A. No. 12:49PM

Q. Was there ever a time when you sat down and explained to her he might have a joint infection? 12:49PM

A. I mean, it definitely was in my rule-outs. My worry was, you're right, is it affecting the tendons, the joint, you know. You know, what's going on from here? And obviously I'm going to send her to a specialist. I'm concerned that it's something severe going on there. 12:49PM 12:49PM 12:49PM 12:49PM 12:49PM 12:50PM

Q. Was there ever a time when you told her that you suspected he had a joint infection or words to that effect? 12:50PM 12:50PM 12:50PM

A. I probably told her what the possibilities were. Like you said, we didn't do the diagnostics to diagnose it. 12:50PM 12:50PM 12:50PM

Q. Was there ever a point in time when you explained to her what the consequences of having a joint infection could be? 12:50PM 12:50PM 12:50PM

A. I'm not sure. 12:50PM

Q. Can you remember doing that? 12:50PM

A. I do not. 12:50PM

Q. You know, though, that the consequences of having a joint infection can be devastating, don't you? 12:50PM 12:50PM

A. Yes. 12:50PM

Q. And you also know that the prognosis for a horse with a joint infection gets worse and worse the longer it goes, right? 12:50PM 12:50PM 12:50PM

A. Yes. 12:50PM

Q. And Harvey's had gone on for a long time, hadn't it? 12:50PM

A. Yes. 12:50PM

Q. Do you have a view as to when the possibility of infection first presented itself -- possibility of a joint infection? 12:50PM 12:51PM

A. It's hard to tell. Normally infections, especially of joint -- well, any infection, they get worse quickly. It's very strange that this went on so long, you know, to me. Months. You know, that just doesn't fit. But when I saw him and the swelling was worse, you know, I'm thinking what we're doing here didn't help. You know, he's got getting better, and that's why I wanted to refer him. 12:51PM

Q. When Dr. Mosley saw him on the 11th -- the 8th of November, it was a lot worse too, right? 12:51PM

A. Well, yeah. We could see the swelling on the x-ray. 12:51PM

Q. In fact, other than the -- other than the fact that it's gotten worse, there is not much change between the time she saw him and the time you saw him, right? 12:51PM

A. Yes. 12:51PM

Q. And a whole month went by almost? 12:51PM

A. Uh-huh. 12:51PM

Q. Isn't that right? 12:51PM

A. Uh-huh. Yes. 12:51PM

Q. Dr. Mosley could have easily referred him to A&M, right? 12:51PM

A. Sure. Anybody could. 12:51PM

Q. Is there any explanation for why a reasonable veterinarian under the circumstances -- under the circumstances they existed on November 8th wouldn't refer Harvey to a specialist or do some diagnostic work, one of the two? 12:51PM 12:52PM 12:52PM 12:52PM

A. Yeah, I'm not sure. 12:52PM

Q. Anything come to mind that would explain that? 12:52PM

A. No, not really. 12:52PM

Q. We've kind of now been through the patient history, which I understand is a cold record. But having now gone through that exercise, is there anything that jogs your memory and suggests to you that Ms. Santerre did something less than what she should have done? That is, was she -- should she have brought him in more often? I mean, we've seen all the times she contacted the clinic on Exhibit 13. Should she have done more than she did? Is that your opinion? Or did she do what a reasonable owner would do in following the instructions of her veterinarian? 12:52PM 12:52PM 12:52PM 12:52PM 12:52PM 12:52PM 12:53PM 12:53PM 12:53PM 12:53PM

A. Yeah. I mean, she, yeah, gave the stuff we prescribed. I can't think of anything that I could 12:53PM

tell. 12:53PM

Q. Now, you know from your discussion with Dr. Watts that when he got to El- -- not Elgin -- when he got to A&M -- 12:53PM

A. Yeah. 12:53PM

Q. -- he had a joint infection, right? 12:53PM

A. Yes. 12:53PM

Q. And what did Dr. Watts do to determine that? What diagnostic procedures did she follow? 12:53PM

A. I didn't write any of her stuff down, but I'm sure they -- they did the ultrasound. They repeated the x-rays, the joint tap with cytology and I'm sure they probably cultured it too. Oh, here we go (indicating). 12:53PM

Q. You wrote down some of what she did? 12:54PM

A. Yeah, I wrote down some of it. Yeah. So that he did have surgery. They flushed the joint. But probably before -- you know, before surgery, they rechecked the x-rays. I'm sure they did a cytology and a culture. 12:54PM

Q. Well, you know she did because it tells you here it's 98 -- is -- or is that from the wash? 12:54PM

A. Yeah, it's from the wash. 12:54PM

Q. 98 percent neutrophils? 12:54PM

A. Uh-huh. 12:54PM

Q. And the threshold is what, 90 percent? 12:54PM

A. Yeah. So I mean -- 12:54PM
Q. So it's above -- definitely above the threshold? 12:54PM
A. Sure. Sure. 12:54PM
Q. And you know that just from looking at that number? 12:54PM
A. Uh-huh. 12:54PM
Q. So Dr. Watts basically did everything that the Divers treatise tells you that you should do if you're dealing with a joint infection, right? 12:54PM
A. Yes. 12:54PM
Q. Exhibit 12, the treatise -- 12:54PM
A. Uh-huh. Yes. 12:54PM
Q. -- that gives step by step? 12:54PM
And he says in his treatise, "Aspiration of joint fluid or cytologic examination and culture and susceptibility testing is essential." 12:55PM
Would you agree with that? 12:55PM
A. Yes. 12:55PM
Q. And again, that's not something that was done at Bastrop Veterinary -- 12:55PM
A. No. 12:55PM
Q. -- Hospital, right? 12:55PM
So far as you know -- well, did you have the expertise to have done that? 12:55PM

A. I could have collected the sample. I would have had to send it off to the lab obviously for culture and sensitivity. We don't run that inhouse. 12:55PM

Q. Right. 12:55PM

A. And I would have sent off the cytology, probably the same lab they did -- they used. 12:55PM

Q. Okay. To your knowledge, could Dr. Schroeder or Dr. Weiss have performed all of the diagnostic procedures that the Divers treatise states are appropriate? 12:55PM

A. I mean, I'm sure they could cut the sample. As far as -- like I said, we don't have the lab to do the culture -- culturing or sensitivity. 12:56PM

Q. Right. 12:56PM

A. We do have a microscope and stain. We can look at cells. But we'd have to send off those samples. 12:56PM

Q. Did you ever receive a copy of any materials from A&M, kind of summaries of what they did or what they found? 12:56PM

A. Well, the fact that I put this in here, I don't -- I think she just called me. I don't think I got the -- the paperwork from them. 12:56PM

(Exhibit 22 marked) 12:56PM

Q. (BY MS. ALLEN) Well, let me show you Exhibit 22, which is their -- what they call the 12:56PM

Veterinary Medical Teaching Hospital
Texas A&M University
(979) 845-3541
http://vethospital.tamu.edu

Equine Orthopedic Surgery Discharge Summary

Owner:
Judy Santerre
836 Cottletown Road
Smithville, TX 78957
Home Phone: 512-480-5670

Patient: #723517, Harvey
DOB: 03/16/03
Weight: 1140 lb, 517.1 kg

Referring Veterinarian:
Lucy Pustejovsky, DVM
Bastrop Veterinary Hospital
2900 Highway 95 North
Bastrop, TX 78602
Phone: 512-321-5386
Fax:512-321-6994

Admission Date: December 04, 2013

Discharge Date: December 31, 2013

Recheck Date: as needed

Senior Clinician: Ashlee Watts, DVM PhD DACVS

Attending Clinician: Kati Glass, DVM

Student:

Presenting complaint: 2.5 month old laceration injury on fetlock, swollen and lame

History: Harvey, a 12-year-old Quarter Horse gelding, was presented to TAMU Orthopedic Service on 12/4/13 for a possible septic fetlock of about 3 months' duration.

Physical Examination: T: 99.7 *F P: 56bpm R: 24bpm

At presentation Harvey was nearly non-weight bearing on the right front limb. A sweat wrap was on the right forelimb. He had received 2 grams of bute that morning and 500 mg of Banamine the previous day. There was an upside-down 'V' shaped scar on the lateral aspect of the RF fetlock. The RF fetlock joint was markedly thickened and swollen and there was very little range of motion of the joint. Otherwise he was bright and alert and his physical examination was within normal limits.

Diagnostic Tests & Results:
Ultrasound exam - there was diffuse and marked thickening of the synovium and joint capsule. There was very little synovial fluid present and the majority of the joint appeared to be filled with thickened tissue. Ultrasound guidance was used to collect a joint wash for cytology.

Joint wash cytology - the joint wash was composed of 98% neutrophils, confirming joint sepsis. Cytologic synovial fluid analysis from the right front fetlock was performed periodically following surgery to monitor resolution of the sepsis.
Radiographic exam - there was diffuse osteopenia of the right forelimb, osteoarthritis of the fetlock joint with joint space narrowing, axial sesamoiditis and abaxial displacement of the proximal sesamoid bones. The LF foot was within normal limits.
Repeat radiographs on 12/16 and 12/24 revealed progression of the fetlock osteoarthritis and fetlock joint collapse. The axial sesamoiditis did not appear to be progressing. Repeat radiographs on 12/31 of the LF foot were within normal limits.
Culture of synovial biopsies - negative
Bloodwork - initial CBC and chemistry were within normal limits. Periodic bloodwork was performed to monitor kidney function. His creatinine remained within normal limits throughout his hospitalization.

Diagnosis: Septic fetlock joint, right forelimb; septic axial sesamoiditis (medial worse than lateral), right forelimb; severe fetlock osteoarthritis, right forelimb

Prognosis: fair for survival, grave for athletic function. As we have discussed, Harvey's lameness is severe and may improve somewhat with time as the soft tissues around and in the joint continue to fibrose (scar) and stabilize the joint. At his current level of lameness, Harvey is still at risk for support limb laminitis. Currently, the plan is for Harvey to return to the hospital in 3 months for fetlock arthrodesis. This amount of time is to minimize the risk of low grade infection persisting and causing infection of the surgical implants used for fetlock arthrodesis. If Harvey's lameness worsens during the next 3 months due to progression of the osteoarthritis, we may need to consider performing fetlock arthrodesis sooner.

Treatment: Right front fetlock arthroscopy for joint lavage, synovectomy, arthrotomies and debridement of the intersesamoidean ligament and axial sesamoiditis was performed on 12/5/13. An indwelling continuous infusion pump was placed during surgery into the right front fetlock joint to dispense amikacin continuously following surgery. The pump was weighed daily to confirm continued function. The pump dispensed an average of 8ml of amikacin (125mg/ml) per day. Harvey was anesthetized with injectable anesthesia (GKX) every 2 to 3 days following surgery for a total of 4 additional fetlock lavages.The continuous infusion pump and all sutures were removed on 12/19/13. Harvey was switched to oral antibiotics only (doxycycline) on 12/27.

Instructions to Owner

Medications: doxycyline - give 1 packet, orally, twice daily for 1 month.

bute - give 1 gram, orally, twice daily. If Harvey improves, you may be able to reduce the dose of bute.

Housing: stall confinement in a deeply bedded stall for the next 2 weeks. If Harvey is walking the same or better in 2 weeks, you may allow access to a very small paddock

(same size as the stall) to allow him to be outside. The paddock should be deep sand (do not allow Harvey to eat off the sand). You may take Harvey out of the stall for handgrazing each day, but no handwalking.

This level of confinement should be continued until the lameness is significantly improved.

Wrapping and boots: you may wean Harvey out of the standing wrap (quilt and polo) over the next week. The soft ride boots should be checked daily for rub sores. The left front boot should be checked without picking up the foot.

Monitoring: for increase swelling of the RF fetlock
- for change in posture (pointing the RF limb)
- for change in the amount of time laying down
- for increased digital pulses or heat in the LF foot

Diet: normal

Call If: there is increased lameness, increased swelling, or if Harvey refuses to turn or move or begins to lie down more frequently as this may indicate laminitis in the left forelimb.

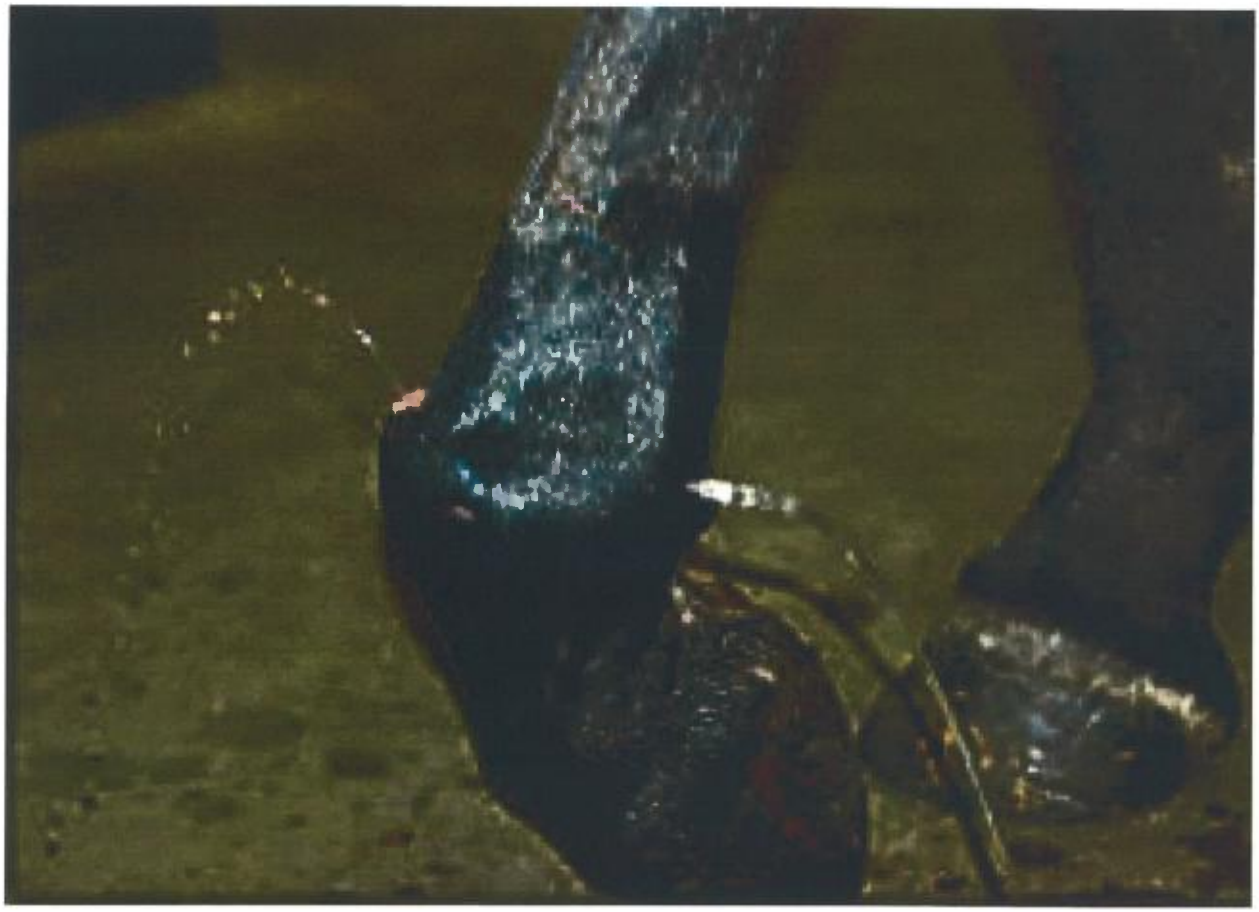
Thank you for bringing Harvey to Texas A&M University. Please call if you have any questions or concerns!

******IF YOU HAVE ANY QUESTIONS OR PROBLEMS, PLEASE DO NOT HESITATE TO CALL – (979) 845-3541*****

_____ Clinician

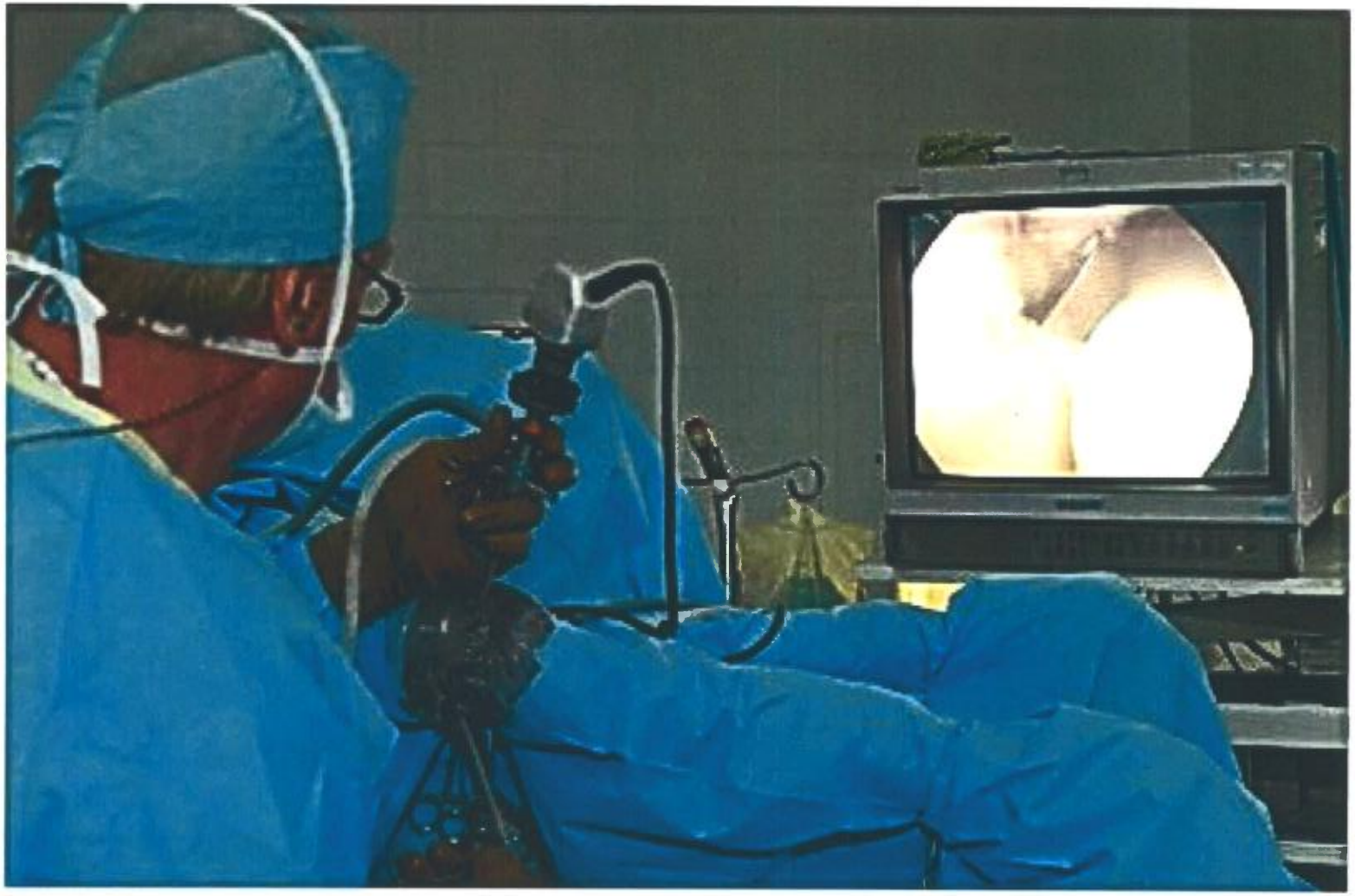
_____ Student

discharge summary --
A. Yeah.
Q. -- from the first time he was there.
A. Uh-huh.
Q. And you can see the date she took him, right?
A. On the 4th, yes.
Q. And then they describe all the procedures that they did?
A. Yes.
Q. And you've described some of those. And we can pretty much -- we could run down the list from the Divers book, but they did pretty much all of them, right?
A. Yes.
Q. And I don't have photographs of Harvey doing it, but I wanted to see if we could -- I found some photographs of some of these procedures to see if we could see what they look like.
A. Sure.
(Exhibit 23 marked)
Q. (BY MS. ALLEN) Can you identify Exhibit 23 as photograph of a --
A. Joint lavage.
Q. -- lavage? That's L-A-V-A-G-E?
A. Uh-huh.



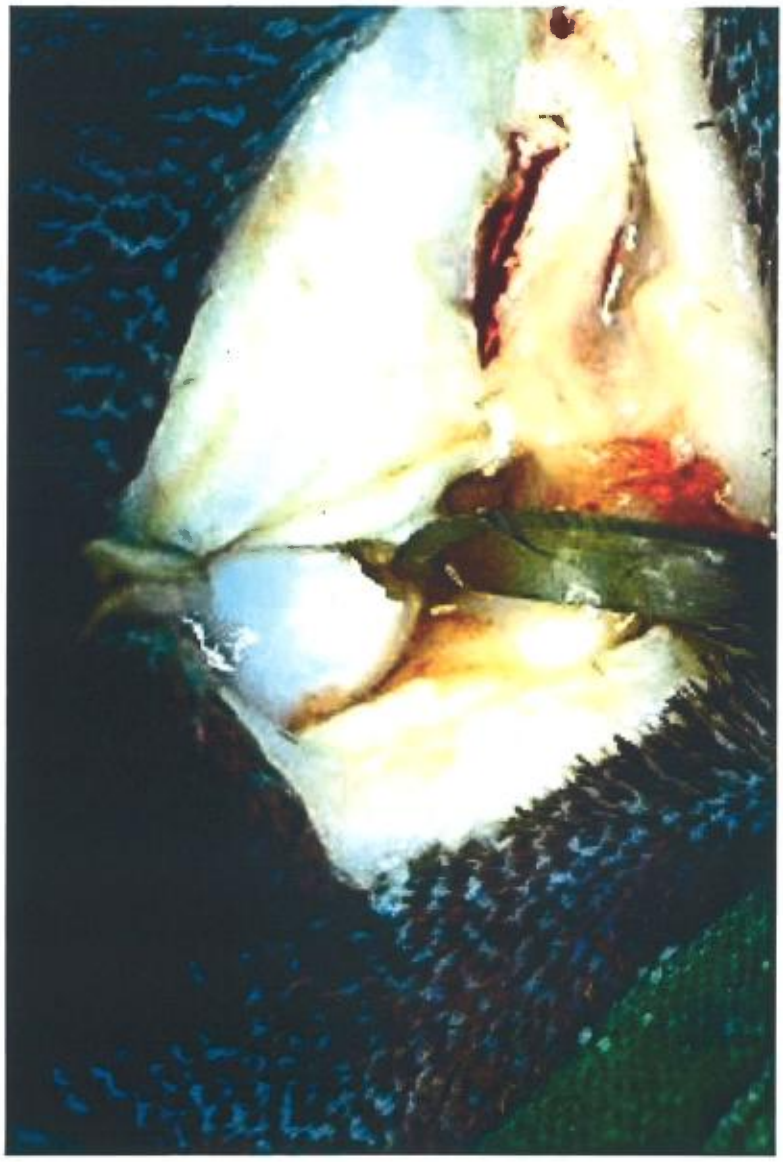
Putajousky
EXHIBIT NO. 23
2-24-14
Julie A. Jordan

Q. And that's one of the things they did at A&M? 12:57PM
A. Yes. 12:57PM
Q. That's one of the things the Divers book says you should do, right? 12:57PM
A. Yes. 12:57PM
Q. Okay. 12:57PM
(Exhibit 24 marked) 12:57PM
Q. (BY MS. ALLEN) And they did some arthroscopic surgery, right? 12:57PM 12:58PM
A. Yes. 12:58PM
Q. Exhibit 24 is a picture that shows what that looks like, isn't it? 12:58PM 12:58PM
A. Yes. 12:58PM
Q. They did a procedure called an arthrotomy? 12:58PM
A. Uh-huh. 12:58PM
Q. Do you know what that is? 12:58PM
A. Yeah, going into the joint. 12:58PM
(Exhibit 25 marked) 12:58PM
Q. (BY MS. ALLEN) And let me show you Exhibit 25. 12:58PM
Can you recognize that as an arthrotomy -- example of an arthrotomy? 12:58PM 12:58PM
A. Yes. 12:58PM
Q. And that's actually incising the joint -- 12:58PM
A. Capsule to go in. Uh-huh. 12:58PM



Postejousky
EXHIBIT NO. 24
2-29-16
Julie A. Jordan

Arthrotomy



Q. -- and going into it and taking a look to see what is there? 12:58PM

A. Uh-huh. 12:58PM

Q. And that's one of the things Divers recommends also, isn't it? 12:58PM

A. Yes. 12:58PM

Q. Or says is part of the protocol? 12:58PM

A. Yes. 12:58PM

Q. And then they installed a pump to deliver -- 12:58PM

A. Antibiotics. Amikacin. 12:58PM

Q. -- amikacin? Amikacin is a powerful antibiotic, call it concentration -- 12:58PM

A. Yes. 12:58PM

Q. -- dependent or something like that? 12:58PM

A. Yes. 12:59PM

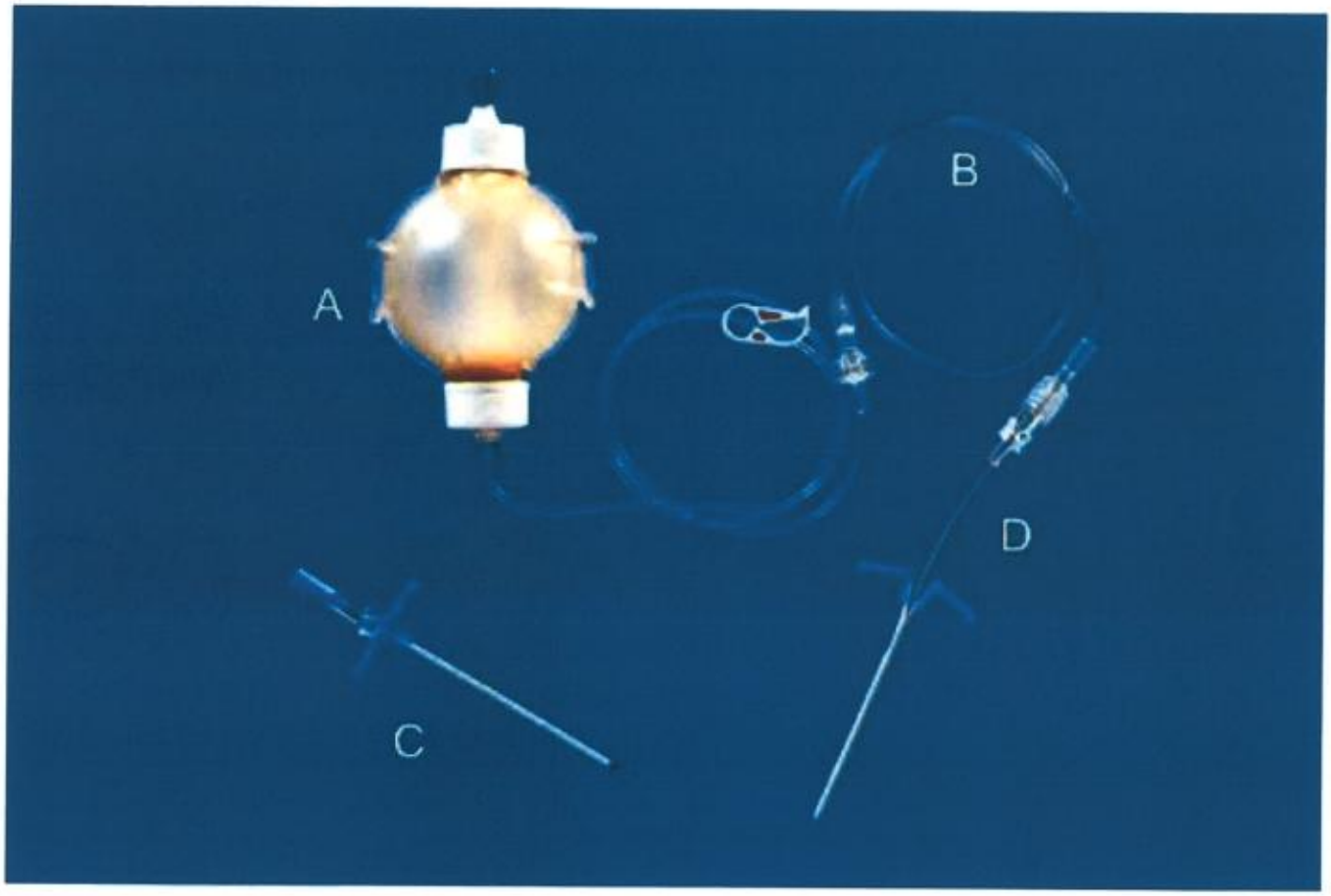
(Exhibit 26 marked) 12:59PM

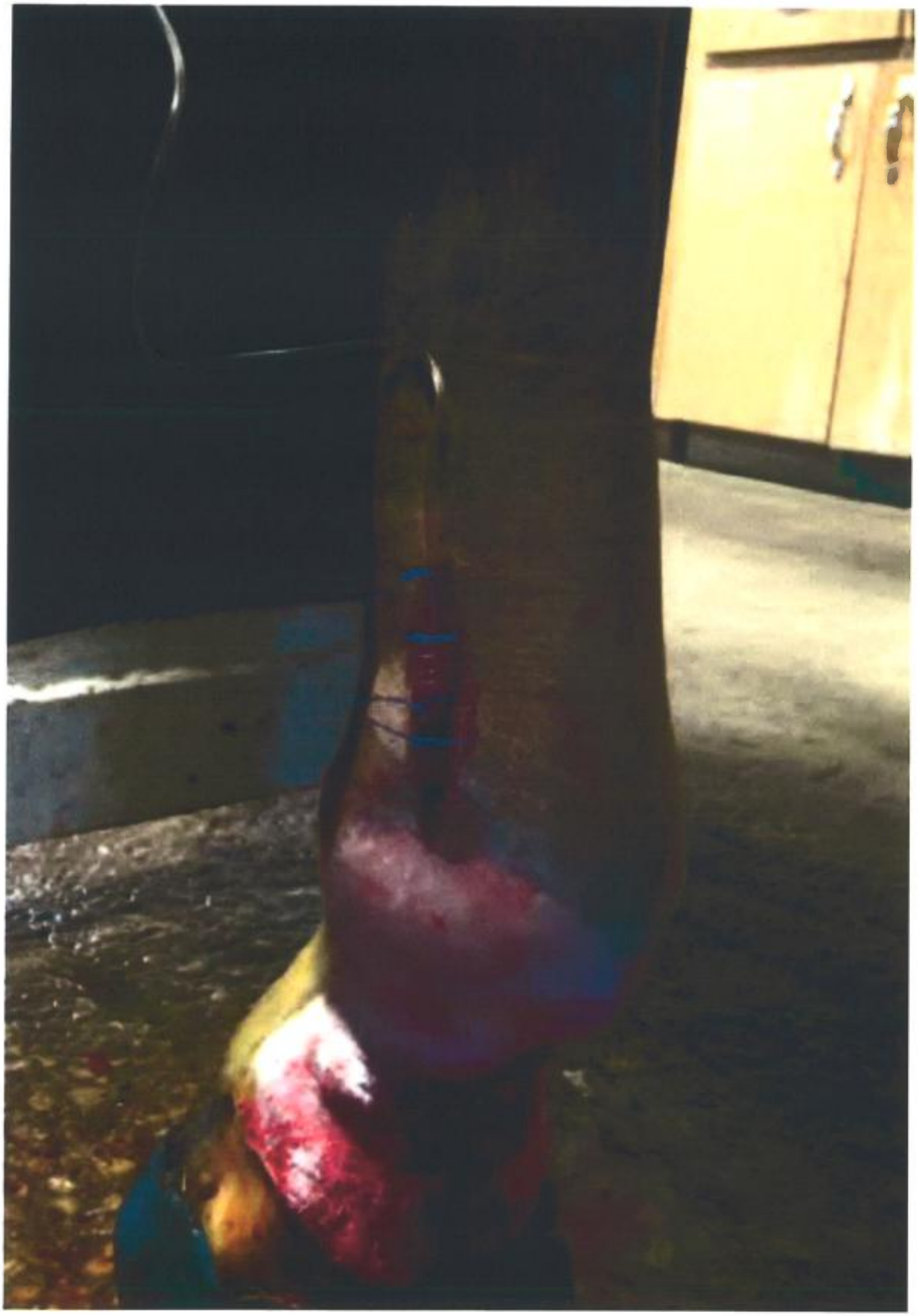
Q. (BY MS. ALLEN) And it requires equipment and procedure, right? 12:59PM

A. Yes. 12:59PM

Q. Exhibit 26, is that a picture of -- on the top the equipment that you used to do it and then what it looks like when it's done on the other two pages? Can you just take a look for me? 12:59PM

A. Oh, sure. I've not seen the pump, but this does look -- I mean, in person I haven't seen it, but it 12:59PM





2013-10-21 11:35

looks like the pump. 12:59PM

Q. And it's mentioned in the discharge summary, but do you know that they did an arthrodesis on him? 12:59PM

A. Yes. Down the road. Uh-huh. 12:59PM

Q. Do you know what that is? 12:59PM

A. Yeah. It's where they fix the fetlock joint. 12:59PM

Q. You mean make it where it can't move? 12:59PM

A. Yes. 12:59PM

Q. By putting screws and whatnot in it? 12:59PM

A. And pins. Uh-huh. 12:59PM

(Exhibit 27 marked) 12:59PM

Q. (BY MS. ALLEN) Let me show you Exhibit 27. 12:59PM

Can you confirm that Exhibit 27 is a photograph of arthrodesis on a fetlock joint? 01:00PM

A. Yes. 01:00PM

Q. And those are all of the procedures that they had to do on Harvey when he presented with the joint infection, right? 01:00PM

A. Yes. 01:00PM

Q. In order to keep him walking on that, right? 01:00PM

A. Yes. 01:00PM

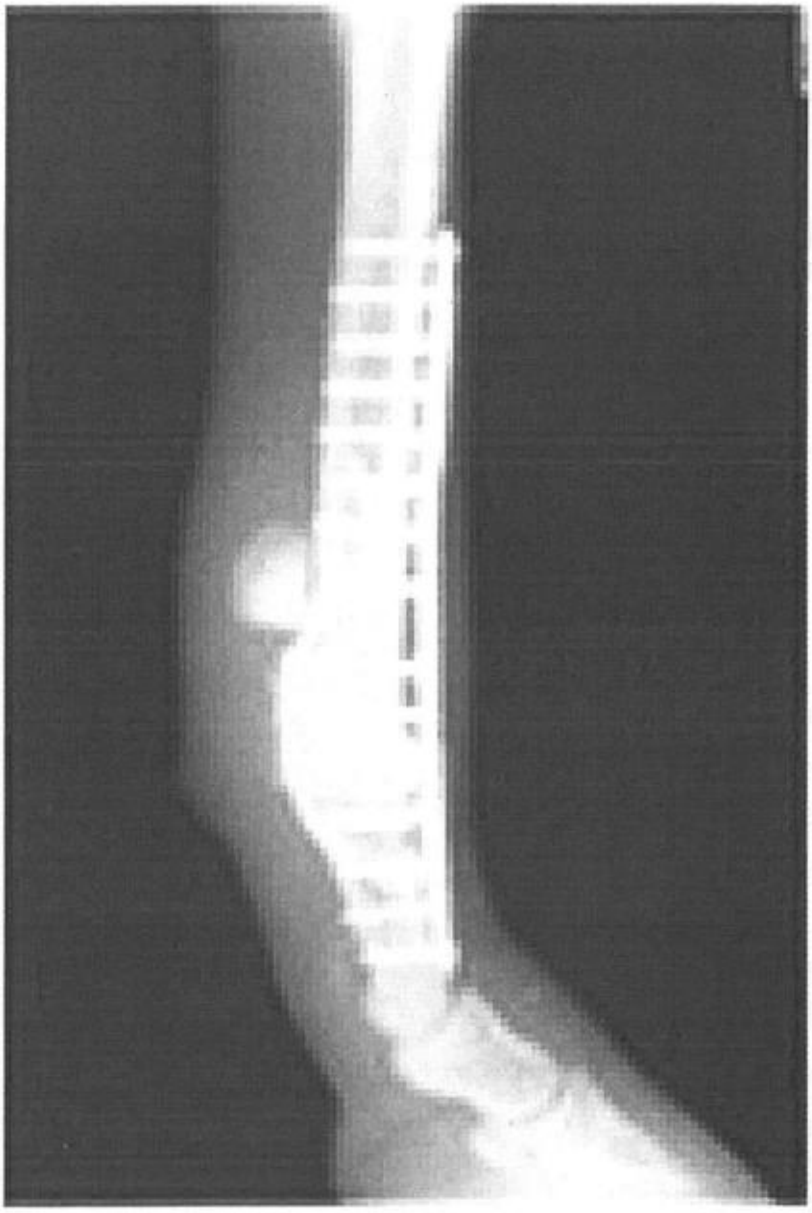
Q. Do you know what happened with him? 01:00PM

A. Yes. 01:00PM

Q. What happened? 01:00PM

A. He became laminitic in his left front and he 01:00PM

ARTHRODESIS



got put down.

Q. And that's very common when you have an injury of one limb, right? 01:00PM

A. Yeah, because the other limb bears more of a weight load. 01:00PM

Q. It's called supporting limb -- 01:00PM

A. Supporting limb -- 01:00PM

Q. -- laminitis -- 01:00PM

A. Yes. 01:00PM

Q. -- isn't it? 01:00PM

A. Yes. 01:00PM

Q. And describe for us what happens when you have laminitis? 01:00PM

A. It's where your coffin bone starts to rotate. And in his case it became so severe that it went through the sole of his foot. 01:01PM

Q. Let me see if I've got a diagram here. Let's try Exhibit 30. 01:01PM

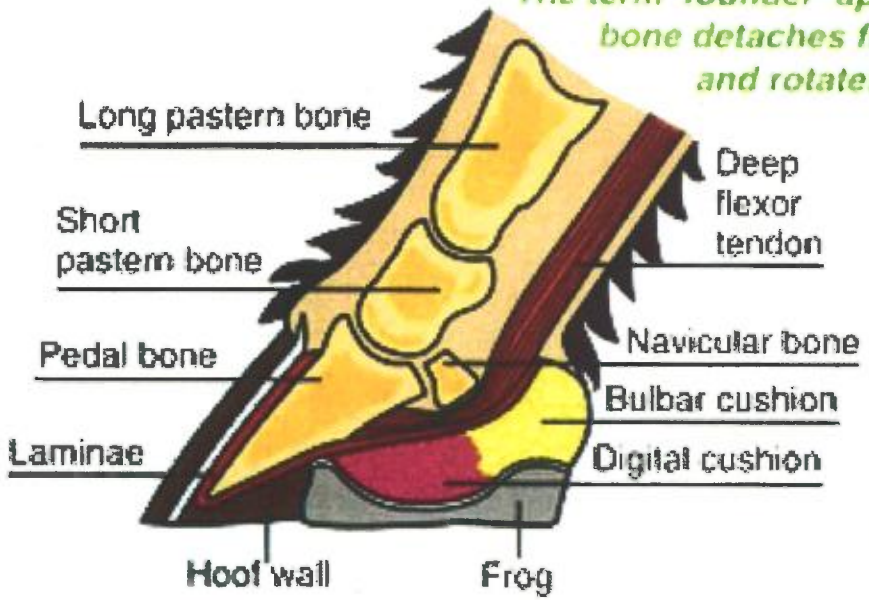
THE REPORTER: 28. 01:01PM

MS. ALLEN: Oops. Scratch that. Okay. Try again. 01:01PM

(Exhibit 28 marked) 01:01PM

Q. (BY MS. ALLEN) I've got a diagram again just to illustrate, if it does illustrate. If it doesn't, you tell me. 01:01PM

'Laminitis' is the term used when the laminae in the foot is inflammed.
The term 'founder' applies when the pedal bone detaches from the laminae and rotates or sinks.



NORMAL FOOT

Pedal bone and lamine intact.

ROTATION

The detached pedal bone can rotate in either direction.

SINKING

Pedal bone is forced downwards to protrude through the sole.

A. Uh-huh. 01:01PM

Q. But taking Exhibit 28, can you kind of describe the progression that you just told us about? 01:01PM

A. So yeah. You mean, like laminitis? 01:01PM

Q. Right. 01:01PM

A. So normally they have normal rotation along their P3, which is their coffin bone. You can start to see some separation off the hoof wall and it starts to rotate downward, which you can catch it. You know, that's an early stage. And then the end stage is if it were to get to where it pops out the sole, the soft surface there, long-term prognosis is grave after that. 01:01PM 01:02PM 01:02PM 01:02PM 01:02PM 01:02PM

Q. At that point, basically you're looking at euthanasia, are you? 01:02PM

A. Yes. 01:02PM

Q. And that's what happened to Harvey, isn't it? 01:02PM

A. Yes. 01:02PM

Q. Did you or, to the best of your knowledge, anybody else at the Bastrop Veterinary Hospital ever sit down with Ms. Santerre and discussion with her the possibility of this support limb laminitis? 01:02PM 01:02PM 01:02PM

A. I did not. 01:02PM

Q. Do you know of anyone else doing it? 01:02PM

A. Not -- I mean, not that I know of. 01:02PM

Q. This is a situation that gets more likely to 01:02PM

happen the longer the one limb is infirm, right? 01:02PM

A. Yes. 01:03PM

Q. So it's important -- that's another reason why it's important to treat promptly an infection or whatever is going on so that you don't have the risk of the support limb laminitis, right? 01:03PM

A. Yes. 01:03PM

Q. Let me show you Exhibit 29. 01:03PM

(Exhibit 29 marked) 01:03PM

Q. (BY MS. ALLEN) Do you see the support limb laminitis in that photograph, Exhibit 29? 01:03PM

A. Yes. 01:03PM

Q. I'll represent to you that's a picture of Harvey's foot when he was put down. 01:03PM

Does that surprise you that it is? 01:04PM

A. No. 01:04PM

Q. Something you would expect to see under the circumstances that he underwent, isn't it? 01:04PM

A. It's definitely a possibility. 01:04PM

Q. Did you ever review any of the invoices, billing statements, if you will, from Texas A&M? 01:04PM

A. I briefly saw some of the paperwork today. 01:04PM

Q. Did you see anything in their billing that you thought was extraordinary or unusual? 01:04PM

A. No. 01:04PM


Pustejovsky
EXHIBIT NO. 29
2-24-16
Julie A. Jordan

Q. In other words, did it appear to you from looking at it that everything they did was reasonable and necessary? 01:04PM

A. Sure. 01:04PM

MR. GOLDSMITH: Objection, form. 01:04PM

Q. (BY MS. ALLEN) To the best of your knowledge -- well, scratch that. 01:04PM

MS. ALLEN: Hang on a second. Bear with me. 01:05PM

THE WITNESS: Sure. 01:05PM

(Exhibit 30 marked) 01:05PM

Q. (BY MS. ALLEN) Let me show you Exhibit 30, which is an excerpt from the rules that pertain to practice of your profession, right? 01:05PM

A. Yes, ma'am. 01:05PM

Q. And so if we look at Section 573.22, 11, it talks about the "Professional Standard of Care." 01:05PM

Do you see that? 01:06PM

A. 573.22, is that what you're talking about? 01:06PM

Q. Yes, ma'am. 01:06PM

A. Uh-huh. 01:06PM

Q. Talks about the "Professional Standard of Care." 01:06PM

Do you understand that the standard -- at least pursuant to these rules, that standard is the 01:06PM

RULES PERTAINING TO THE PRACTICE OF VETERINARY MEDICINE

TEXAS ADMINISTRATIVE CODE
TITLE 22, PART 24
CHAPTER 573

TEXAS BOARD OF VETERINARY MEDICAL EXAMINERS
333 Guadalupe, Ste. 3-810
Austin, TX 78701-3942
Phone: 512/305-7555
Fax: 512/305-7556

E-Mail: vet.board@tbvme.state.tx.us
Website: http://www.tbvme.state.tx.us

November 22, 2015

(c) Nothing in this regulation shall prohibit any person from utilizing cotton swabs, gauze, dental floss, dentifrice, or toothbrushes to clean an animal's teeth.

(d) In dogs and cats, a licensed veterinary technician under direct or immediate supervision of a veterinarian may extract loose teeth or dental fragments with minimal periodontal attachments by hand and without the use of an elevator.

(e) The following treatments may be performed to an equid by a licensed equine dental provider under general supervision by a veterinarian, and by a non-veterinarian employee under direct supervision by the veterinarian:

(1) removing sharp enamel points;

(2) removing small dental overgrowths;

(3) rostral profiling of the first cheek teeth;

(4) reducing incisors;

(5) extracting loose, deciduous teeth;

(6) removing supragingival calculus;

(7) extracting loose, mobile, or diseased teeth or dental fragments with minimal periodontal attachments by hand and without the use of an elevator; and

(8) removing erupted, non-displaced wolf teeth.

Source Note: *The provisions of this §573.19 adopted to be effective December 25, 2012, 37 TexReg 9936; amended to be effective August 29, 2013, 38 TexReg 5487; amended to be effective May 4, 2014, 39 TexReg 3427*

SUBCHAPTER C RESPONSIBILITIES TO CLIENTS

§573.20 Responsibility for Acceptance of Medical Care

(a) The decision to accept an animal as a patient is at the sole discretion of a veterinarian. The veterinarian is responsible for determining the diagnosis and course of treatment for an animal that has been accepted as a patient and for advising the client as to the diagnosis and treatment to be provided.

(b) For purposes of establishing a veterinarian-client-patient relationship under §801.351 of the Veterinary Licensing Act, Texas Occupations Code, a veterinarian can obtain sufficient knowledge of an animal by making medically appropriate and timely visits to the premises on which the animal is kept only if the animal is a member of a herd.

(c) A veterinarian must inform a client when:

(1) the client has specifically requested that the veterinarian diagnose and/or treat the client's animal; and

(2) the veterinarian reasonably believes there is a likelihood or possibility that another veterinarian may perform some or all of the diagnosis and/or treatment of the patient.

(d) Once a veterinarian-client-patient relationship has been established, a veterinarian may discontinue treatment:

(1) at the request of the client;

(2) after the veterinarian substantially completes the treatment or diagnostics prescribed;

(3) upon referral to another veterinarian; or

(4) after notice to the client providing a reasonable period for the client to secure the services of another veterinarian.

(e) Once a veterinarian establishes a veterinarian-client-patient relationship and prescribes medication(s), another Texas licensed veterinarian within the same clinic or hospital who has access to the patient's current medical records may refill that same prescription(s) without a veterinary-client-patient relationship.

Source Note: *The provisions of this §573.20 adopted to be effective June 14, 2012, 37 TexReg 4229; amended to be effective August 29, 2013, 38 TexReg 5487; amended to be effective May 4, 2015, 40 TexReg 2418*

§573.21 Direct Responsibility to Client

The professional services of a licensee shall not be controlled or exploited by any lay agency, personal or corporate, which intervenes between the client and the licensee. A licensee shall not allow a non-licensed person or entity to interfere or intervene with the licensee's practice; nor shall the licensee submit to such interference or intervention by a non-licensed person or entity. A licensee shall avoid all relationships which could result in interference or intervention in the licensee's practice by a non-licensed person or entity. A licensee shall be responsible for his or her own actions and is directly responsible to the client and for the care and treatment of the patient.

Source Note: *The provisions of this §573.21 adopted to be effective June 14, 2012, 37 TexReg 4229*

§573.22 Professional Standard of Care

Licensees shall exercise the same degree of humane care, skill, and diligence in treating patients as are ordinarily used in the same or similar circumstances, including the type of practice, by average members of the veterinary medical profession in good standing in the locality or geographic community in which they practice, or in similar communities.

Source Note: *The provisions of this §573.22 adopted to be effective June 14, 2012, 37 TexReg 4229; amended to be effective May 4, 2015, 40 TexReg 2419*

§573.23 Board Certified Specialists

(a) Standard of Care for Specialist. Specialists are held to a higher standard of care than non-specialist veterinarians, notwithstanding §573.22 of this title (relating to Professional Standard of Care).

(b) Complaints against Specialists. Board investigations of complaints alleging substandard care by a Specialist in his/her area of specialty will include consultations with one or more Specialists licensed by the Board practicing the same specialty on the species involved in the complaint. The Board, at its sole discretion, may consult with Specialists from outside of Texas. If the Board determines an informal conference is warranted, both complainant and respondent may, at their own expense, present oral or written commentary by a Specialist practicing the same specialty on the species involved in the complaint.

(c) Verification of Specialist Status. Specialists must make information verifying their certification or recognition as a specialist available to the Board, Board staff, and the public. This information must be available upon request.

Source Note: *The provisions of this §573.23 adopted to be effective June 14, 2012, 37 TexReg 4229; amended to be effective August 17, 2015, 40 TexReg 5153*

§573.24 Responsibility of Veterinarian to Refer a Case

(a) A veterinarian shall have a duty to a client to suggest a referral to a specialist, or otherwise more qualified veterinarian, in any case where the care and treatment of the animal is beyond the veterinarian's capabilities. A veterinarian's decision on whether to accept or continue care and treatment of an animal, which may require expertise beyond the veterinarian's capabilities, shall be based on the exercise of sound judgment within the prevailing standard of care for a veterinarian faced with the same or similar circumstances.

(b) Complaints Regarding Failure to Make Proper Referral. Board investigations of complaints alleging failure to properly make referrals will include evaluation of the training and experience of the veterinarian, the availability of a specialist or more qualified veterinarian, the timeliness and adequacy of information provided to the client regarding the possible need for a referral, the requests of the client, and the likelihood that an adverse result could have been prevented by a timely referral.

Source Note: *The provisions of this §573.24 adopted to be effective June 14, 2012, 37 TexReg 4229*

§573.25 Issuance of Official Health Documents Through Direct Knowledge Only

Licensed veterinarians in this state shall not issue any official health documents for an animal without first having personally examined the individual animal and know of their own knowledge, by actual inspection and appropriate tests, that said animal meets the requirements for the issuance of the official health document. A veterinarian is deemed to have issued and to have knowledge of any official health documents issued in the veterinarian's name, written by veterinarian's employee and/or maintained in veterinarian's patient or client files. A veterinarian shall be responsible for the security and proper use of all official certificates, forms, records and reports, and shall take reasonable care to prevent the misuse thereof. A veterinarian shall immediately report to the TBVME the loss, theft or deliberate or accidental misuse of any such certificate, form, record or report.

Source Note: *The provisions of this §573.25 adopted to be effective June 14, 2012, 37 TexReg 4229*

§573.26 Avoidance of Guaranteeing Cures

It is professionally dishonest for a licensee to guarantee a cure. A licensee must avoid bold and confident assurances to clients, especially where the licensee's employment may depend upon such assurance.

Source Note: *The provisions of this §573.26 adopted to be effective June 14, 2012, 37 TexReg 4229*

§573.27 Honesty, Integrity, and Fair Dealing

Licensees shall conduct their practice with honesty, integrity, and fair dealing to clients in time and services rendered, and in the amount charged for services, facilities, appliances, and drugs.

Source Note: *The provisions of this §573.27 adopted to be effective June 14, 2012, 37 TexReg 4229*

standard that is applicable to the work that you do? 01:06PM
A. Yes. 01:06PM
Q. At least under -- insofar as these rules are concerned? 01:06PM
A. Yes. 01:06PM
Q. Do you agree that standard requires you to follow the generally accepted practices and protocols to deal with the circumstances that you're presented with in your equine patients? 01:06PM
A. Yes. 01:06PM
Q. If you flip back to Page 10, 573.20 talks about "Responsibility for Acceptance of Medical Care," right? 01:07PM
A. Yes. 01:07PM
Q. It says, "The veterinarian is responsible for determining the diagnosis and course of treatment for an animal that has been accepted as a patient and for advising the client as to the diagnosis and treatment to be provided." 01:07PM
You understand that's one of the duties that you had to Ms. Santerre, right? 01:07PM
A. Yes. 01:07PM
Q. And that all the vets at Bastrop Veterinary Hospital had to her, correct? 01:07PM
A. Yes. 01:07PM

Q. And then on Page 12, 573.24 talks about "Responsibility of Veterinarian to Refer a Case." 01:07PM

Do you see that? 01:07PM

A. Yes. 01:07PM

Q. "A veterinarian shall have a duty to a client to suggest a referral to a specialist, or otherwise more qualified veterinarian, in any case where the care and treatment of the animal is beyond the veterinarian's capabilities." 01:07PM

Do you see that? 01:07PM

A. Yes. 01:07PM

NO Q. Is that what you did? 01:07PM

A. Yes. 01:07PM

Q. Was Harvey's care and treatment beyond the capabilities of Dr. Mosley? 01:08PM

A. I can't speak on her behalf. 01:08PM

Q. Don't have to speak on her behalf, but you worked with her and you observed her. 01:08PM

And was Harvey's care and treatment beyond the scope of her capabilities? 01:08PM

A. I mean, I guess. I mean, I referred him, so I guess. 01:08PM

FALSE

Q. How about Dr. Schroeder and Dr. Weiss? 01:08PM

A. I don't know. It's hard to -- I mean... 01:08PM

Q. If you don't know, then that's a perfectly 01:08PM

fine answer. 01:08PM

A. Okay. I don't know. Yeah. 01:08PM

Q. I'm not asking you to make stuff up. 01:08PM

A. Okay. Thank you. 01:08PM

Q. Just tell us what you know. 01:08PM

A. Okay. 01:08PM

Q. There's one more thing that I wanted to visit with you about. And I'm going to have to put my hands on it. 01:08PM

(Exhibit 31 marked) 01:09PM

Q. (BY MS. ALLEN) Let me show you Exhibit 31 and ask if you can take a look at that and see if you want to compare to the book. They're excerpts from the Divers treatise on laminitis, right? 01:09PM

A. Uh-huh. 01:09PM

Q. And I'll give you a chance to take a look at that for just a minute. 01:09PM

A. (Reviewing document.) 01:09PM

Q. I'm sorry. Do you -- you got a chance to look at it? 01:10PM

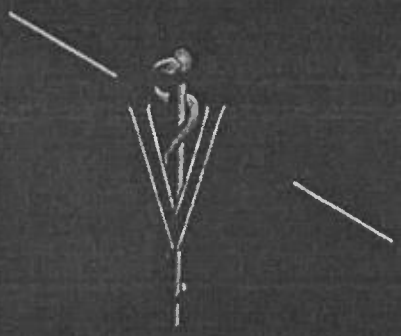
A. Yeah. 01:10PM

Q. Okay. Okay. And one of -- what Divers says is one of the causes of onset of acute laminitis is "Continuous forced weight bearing on a single foot," right? 01:10PM

Manual of Equine Emergencies

Treatment and Procedures

Second Edition



James A. Orsini
Thomas J. Divers

SAUNDERS

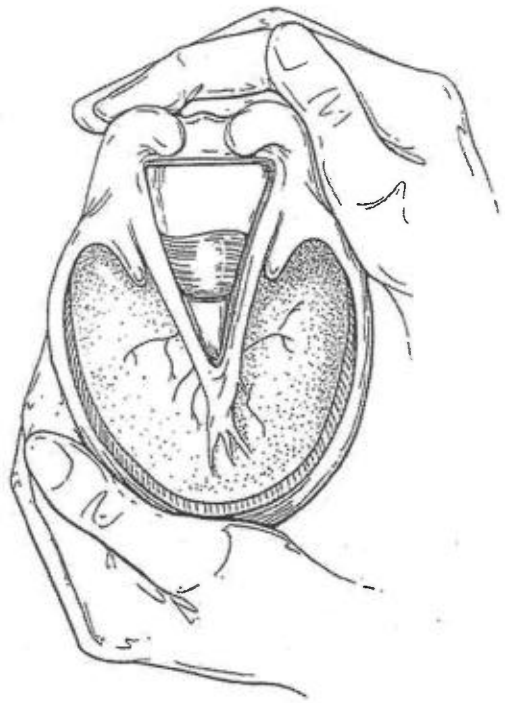


FIGURE 39-10. With punctures in the middle third of the frog, damage to the navicular bone or its bursa should be suspected. A street nail operation or the preferred technique of "Endoscopy of the Navicular Bursa" (see pp. 000) may be needed to drain the bursa and see the navicular bone.

LAMINITIS (FOUNDER)

David M. Hood

Types

- Developmental laminitis
- Acute laminitis
- Subacute laminitis
- Chronic laminitis

Developmental Laminitis

Definition

- High risk of development of laminitis because of exposure to an identifiable cause or predisposing factor

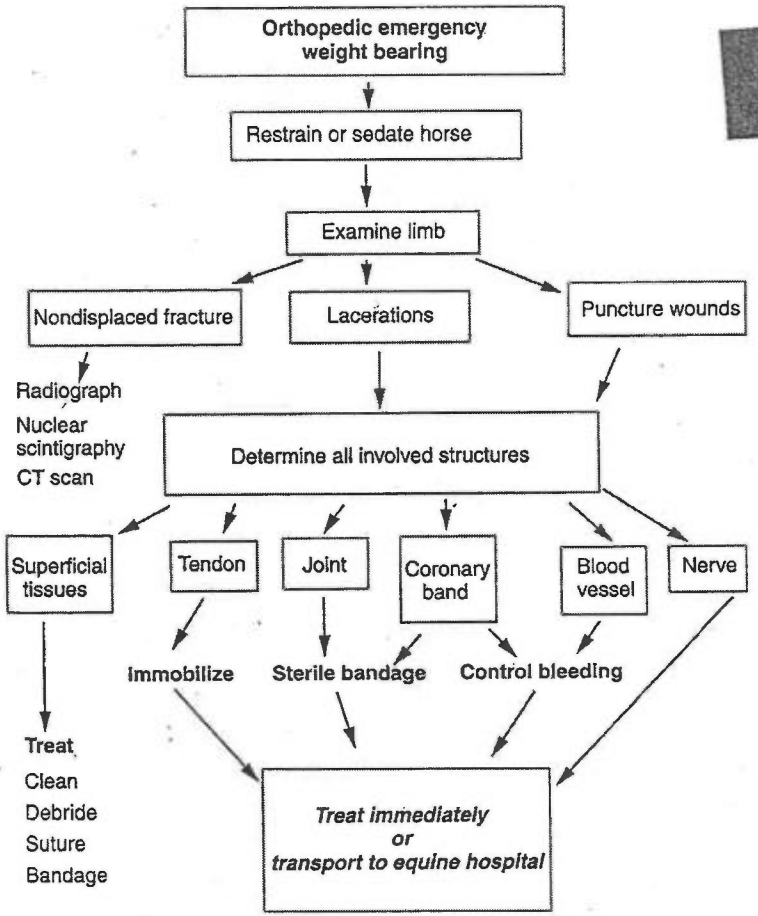


FIGURE 39-11. Algorithm for emergency management of weight-bearing problems.

Causes: Events and Factors Correlating with the Onset of Acute Laminitis

- Carbohydrate overload
- Retained placenta
- Gastrointestinal disease
- Trauma
  - Overexercise on hard surfaces
  - Continuous forced weight bearing on a single foot
- Exposure to black walnut (*Juglans nigra*) wood shavings
- Any systemic problem resulting in hypovolemia or a hypotensive state

Predisposing Factors
- Corticosteroids
- Obesity
- Equine Cushing's disease

Signs
- Asymptomatic relative to digital pain
- Feet may be cold and insensitive

Principal Pathologic Changes
- Submural blood flow reduced
- Laminar epidermal cells show mild nuclear pyknosis and cytoplasmic vacuolization (edema)

Preventive Measures
- Remove or limit exposure to the cause or predisposing factors
- Mineral oil through a nasogastric tube in cases of carbohydrate- or protein-rich feed overload
- Manage primary systemic disease, such as colic, diarrhea, sepsis, retained placenta
- Provide sole support for foot exposed to continued loading
- NSAIDs
  - Phenylbutazone (2.2 mg/kg IV or PO q12h)
  - Flunixin meglumine (1.1 mg/kg IV q24h)
- Improve digital blood flow
  - Maintain adequate circulatory volume
  - Vasodilator therapy (acepromazine 0.02-0.06 mg/kg IV q6h)
  - Rheologic therapy (pentoxifylline, 8.4 mg/kg PO q12h)

Acute Laminitis

Definition
- Signs of pain with or without evidence of an associated cause or predisposing factor

Causes
- See earlier.

Digital Signs: Digital Pain and Lameness
- Pain, if recognized early, usually is subtle but can rapidly progress to severe lameness in 6-12 hours.
- Lameness generally involves more than one foot. One foot may be more severely affected and lameness referable to one foot.
- Increased digital pulse due to systemic hypertension and inflammation.

NOTE: Not a consistent finding; depends on severity and duration of disease.

- Heat felt over hoof wall owing to hyperemia and inflammation.

NOTE: Not a consistent finding; depends on severity and duration of disease.

- Altered stance: Patient typically stands with the forefeet and hindfeet forward of the normal position. The classic stance for laminitis may not be present if the disease is mild or if all four feet are affected.
- Altered gait: Varies markedly depending on the severity of disease. In early, mild disease the patient may only have a shortened or stilted gait and an unwillingness to turn.

Systemic Signs
- Hypertension, tachycardia, pyrexia, mild metabolic acidosis and inappetence

Principal Pathologic Changes
- Submural blood flow is increased.
- Digital changes demonstrate a cascade that includes reperfusion hyperemia, reperfusion injury, and a secondary vascular compartment injury.
- Lesions seen: Dermal endothelial cell activation, microthrombosis, occasional perivascular hemorrhage, epithelial cell pyknosis, vacuolization, and necrosis affecting the peripheral regions of the submural laminar interface in the early acute stages. If the disease progresses in severity, lesions may extend to the axial areas of the laminar interface, and separation of the epithelial basement membrane may occur.

Diagnosis
- Based on presence of acute digital pain and lameness with or without elevated digital pulses and warm feet
- Radiographs and physical examination of the feet are needed to rule out preexisting laminar disease and chronic laminitis:
  - Rotation
  - Sinking
  - Flat feet
  - Widened white line
  - Depressed coronary band
- Judicious use of diagnostic nerve blocks is useful to rule out other causes of lameness.

Treatment Goals
- Limit the pathologic cascade occurring in the submural laminar interface.
- Reduce pain.
- Protect the damaged interface from mechanical overload that predisposes to mechanical failure.
- Administer NSAIDs:

NOTE: Administer NSAIDs as early as possible to limit the progression of the disease and improve comfort.

  - Phenylbutazone (2.2 mg/kg IV followed by 2.2 mg/kg q12h PO for 3 days)
  - Flunixin meglumine (1.1 mg/kg IV q24h)
- Minimize injury to foot.
  - Sole support with deep sand bedding if the horse is standing, or wood shavings if recumbent.

- Sole support for the posterior part of the foot. Pads should provide support and be nonrigid. Examples include Styrofoam, Equilox, and Lily pads.

NOTE: Pads should not extend in front of the point of the frog.

- Do not walk or trailer the horse. Increased loads damage the laminar and sole interface and can result in mechanical failure of the foot.

Although controversial, continual application of ice to the foot may decrease reperfusion injury. This can be easily achieved by placing crushed ice in an empty 5 L fluid bag and using it as a boot.

Subacute Laminitis

Definition

- The patient recovers from an acute episode without mechanical failure of the foot.

Cause

- An episode of acute laminitis

Signs

- Affected horses are mildly lame but frequently have no symptoms of digital disease.

Principal Pathologic Changes

- Submural laminar interface changes with mild epithelial hyperplasia and bleeding in the hoof wall and sole

Diagnosis

- History of acute laminitis within the last 3-6 months combined with radiographic and physical examination findings revealing no abnormalities of the foot

Treatment Goals

- Protect the healing laminar interface during healing; analgesics as needed.
  - Analgesics: NSAIDs use in subacute laminitis should be limited to the lowest dose for pain management.
- Protection of the foot:
  - After an acute episode, exercise is limited for 3-6 months depending on the severity of the initial disease: No riding, hand trotting, or walking on hard roads.
- *No* long distance trailering is recommended; if trailering is necessary, provide good sole support.
- Treatment support shoes can be used to reduce laminar interface loading.

Chronic Laminitis

Definition

- The radiographic or physical findings show mechanical collapse of the foot.

Cause

- A previous episode of acute laminitis
- Acute mechanical collapse in a horse with subacute laminitis caused by excessive loading of the healing foot
- Serial episodes of laminitis associated with mechanical injury, vascular insults, or sepsis

Signs

- Pain, lameness
  - Asymptomatic: Compensated chronic laminitis
  - Symptomatic: Uncompensated chronic laminitis with severe pain and lameness
  - Many horses with chronic laminitis have no symptoms
- Evidence of digital collapse or altered growth of the hoof includes:
  - Sunken coronary band
  - Coronary shear lesions
  - Founder rings
  - Long curved toes or an acute change in the dorsal wall contour
  - Evidence of repeated sole or wall hemorrhage
  - Overgrown heels
  - Flattened or dropped soles
  - Widened white line
  - Sole or coronary abscesses
  - Sole penetration

Systemic signs

- Endocrine disease
  - Equine Cushing's disease
  - Stress-induced hypothyroidism (euthyroid sick syndrome)
- Systemic hypertension
- Hyperreactive immune system
- Renal disease

Principal Pathologic Changes

MECHANICAL COLLAPSE OF THE FOOT

- Displacement of the distal phalanx relative to the hoof capsule
  - Phalangeal rotation
  - Capsular rotation
  - Vertical displacement of P3
- Digital instability: An increased mobility of the distal phalanx and hoof capsule associated with the type of healing occurring in the submural tissue.
- Reduced strength of the laminar interface: Weakening of the laminar interface due to changes in the architecture and the healing response.

METABOLIC DISEASE OF THE LAMINAR INTERFACE

- The healing of the laminae exists as a noncornifying, basal cell hyperplasia predisposed to digital instability and reduced strength of the laminar interface. More appropriate healing leads to a cornifying or partially cornifying laminar hyperplasia predisposed to a clinically compensated, less painful patient.

A. Yes. 01:10PM
Q. That's what we're talking about here? 01:10PM
A. Supportive limb, yeah. 01:10PM
Q. Okay. And one of the preventative measures is resolving what has made the other limb nonweight bearing, if you will, right? 01:10PM
A. Yes. 01:10PM
Q. And doing it as quickly as you can. That's the generally accepted practice for dealing with this type of laminitis, isn't it? 01:10PM
A. Yes. 01:10PM
Q. And really nothing else is -- is anything else going to deal with this? 01:10PM
A. I mean, there's treatment for laminitis, but that's one of your first steps. 01:11PM
Q. Is resolving what is ailing the other limb, correct, so you can get some of the weight off of it? 01:11PM
A. Uh-huh. 01:11PM
Q. Okay. And even if it has begun, that is, the laminitis process has begun, if you can resolve what is ailing the other limb, then you can stop that process at a point, correct? 01:11PM
A. Usually, yes. 01:11PM
Q. You -- 01:11PM
A. Sometimes laminitis -- once it starts, it's 01:11PM

hard to turn it around. 01:11PM

Q. You can't probably stop it once the coffin bone is rotated and pointed down? 01:11PM

A. Oh, no. Or -- yeah, if it's already protrusion, yeah, you can't change it. 01:11PM

Q. Okay. I -- from looking at the treatment notes from the Bastrop Veterinary Hospital, I cannot find any reference to giving any attention to the other foreleg to determine whether or not it was developing laminitis. 01:11PM

Did you have see any of that in the treatment notes? 01:11PM

A. I did not. Normally to check for rotation, you take an x-ray. I didn't notice any. 01:11PM

Q. No x-rays of that? 01:12PM

A. No. 01:12PM

Q. Let's see. That would have been the -- 01:12PM

A. Left front. 01:12PM

Q. Left front. 01:12PM

And no indication -- you couldn't see any indication, could you, that there had been any other diagnostic to try to determine whether or not Harvey was developing support limb laminitis, right? 01:12PM

A. No. And I guess looking for clinical signs, he didn't seem uncomfortable on it, you know. He didn't 01:12PM

show any signs of that yet. But seems like it developed as it progressed. 01:12PM

Q. But you knew even then that the longer he was lame on the foot with the joint infection, the worse that it was going to be for the support limb, right? 01:12PM

A. Uh-huh. There's always the potential for the support limb laminitis. 01:12PM

Q. Do you have any way of knowing when his support limb started developing laminitis? 01:13PM

A. I'm not sure. I know I briefly looked through A&M's records and they took multiple x-rays. So that would be something that we could compare to. 01:13PM

Q. So compare their x-rays to your x-rays? 01:13PM

A. Well, just from the -- you know, compare their -- look at their x-rays because you can see if there was rotation or not. 01:13PM

Q. Okay. And if I'm understanding correctly, laminitis is -- I sort of picture it as tearing your fingernail away from your skin. 01:13PM

Is it something like that? 01:13PM

A. The -- the -- the bone separates from the hoof wall and that's when it moves down. 01:13PM

Q. And the lamina is what's in there that's -- 01:13PM

A. Uh-huh. 01:13PM

Q. -- kind of the glue, but -- 01:13PM

A. Exactly. 01:13PM
Q. -- it all separates? 01:13PM
A. Uh-huh. 01:13PM
Q. And it's very, very painful, isn't it? 01:13PM
A. Yes. 01:13PM
Q. Or it's thought to be. They can't tell you. 01:13PM
A. Well, yeah. But we assume it's painful. 01:13PM
Q. Okay. Divers in Exhibit 31 tells the generally accepted protocol for diagnosing it and dealing with it and it is laminitis, correct? 01:13PM 01:14PM 01:14PM
A. Huh? 01:14PM
Q. The Divers treatise tells us the authoritative protocol for how to diagnose and deal with support limb laminitis, correct? 01:14PM 01:14PM 01:14PM
A. Yes. 01:14PM
Q. And none of those steps were taken at Bastrop Veterinary Hospital, correct? 01:14PM 01:14PM
A. No. 01:14PM
Q. Dr. Lucy, when we started, we marked some of your discovery responses. And I know we've now buried those, but if you could find for us the request for admissions. 01:14PM 01:14PM 01:14PM
MR. GOLDSMITH: (Indicating.) 01:14PM
A. Okay. No. 3. 01:14PM
Q. (BY MS. ALLEN) No. 3. Great. Thanks. 01:14PM

Before we do that, though, now that we've gone back and really put pen to paper on the dates on Exhibit 13, do you see any large gaps of treatment where you think that Judy Santerre wasn't doing what she was supposed to do with her horse? 01:14PM 01:15PM 01:15PM 01:15PM 01:15PM

A. No. 01:15PM

Q. Okay. Now, if you look on Page 3 with me of Exhibit 3, Request No. 11 asked on the -- when he was first brought in for treatment and before he was released to go home in September of 2013 -- 01:15PM 01:15PM 01:15PM 01:15PM

A. Uh-huh. 01:15PM

Q. -- no veterinarian "took steps to prevent or detect a joint infection in Harvey's right front ankle." And that was denied and I want to understand the basis for that being denied. 01:15PM 01:15PM 01:16PM

A. Let me read it. 01:16PM

Q. Sure. 01:16PM

A. (Reviewing document.) I believe I know why it was denied. The steps to prevent it were they did start him on antibiotics, so that's probably why we denied it. 01:16PM 01:16PM 01:16PM

Q. The SMZ? 01:16PM

A. Yes, ma'am. 01:16PM

Q. Got you. 01:16PM

Is there something like Divers or something authoritative that would help us to know what 01:16PM

September 2013 – August 2014

September

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

October

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

November

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

December

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

January

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

March

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

April

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

May

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

July

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

August

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Pustejovsky
EXHIBIT NO. 13
2-29-16
Julie A. Jordan

- Mosely
- Moore
- Weiss
- Schroeder
- Lucy

the generally accepted practice is concerning the administration of SMZ over a long period? 01:16PM

A. You can look in a pharmacology book. Might be better -- because that just gave you a chart. We use Plumb's. That's the pharmacologic book that I most commonly use, Plumb's, P-L-U-M-B-S. It's your formulary. So it gives you side effects, dosing, you know, every -- you know, what you want to look for for any type of medication. 01:16PM 01:16PM 01:17PM 01:17PM 01:17PM 01:17PM 01:17PM

Q. And what I'm looking for, Doc, is help to try to evaluate whether the giving of SMZ over a two-plus-month, almost three-month period was the right thing to do. 01:17PM 01:17PM 01:17PM 01:17PM 01:17PM

And Plumb's would be the book to go to, you think? 01:17PM 01:17PM

A. It would be a good start. Uh-huh. 01:17PM

Q. Okay. If you will turn to Page 4, we've got those photographs somewhere, but on 16 it says, "The photographs of Harvey's right front ankle that Judy" sent showed "swollen right front ankle joint and yellowish discharge," and that is denied. 01:17PM 01:17PM 01:17PM 01:17PM 01:18PM

Those photographs are around here somewhere. We can pull them out if we needed to. 01:18PM 01:18PM

A. Yes. 01:18PM

Q. But we've seen them here today or I wouldn't 01:18PM

have asked you this otherwise. 01:18PM

A. No. Yeah. 01:18PM

Q. Can you explain to me why that one was denied? 01:18PM

A. (Reviewing document.) I believe we did see -- I mean, you could see the swelling in the picture and the discharge. I guess the fact that it says coming from the joint. 01:18PM

Q. Oh -- 01:18PM

A. From the picture we couldn't tell. 01:18PM

Q. Couldn't tell? 01:18PM

A. Yeah. I mean, we knew it was there, so if you wouldn't have had that, then I would have agreed to that. 01:18PM

Q. That makes sense. You just couldn't tell whether it was coming from the joint or somewhere else? 01:18PM

A. Yeah. Soft tissue, skin, you know. 01:18PM

Q. Okay. And again, the only way you could have told if it was coming from the joint was to take the steps in the Divers book, right? 01:18PM

A. Yes. 01:18PM

Q. Okay. Or you could tell it wasn't coming from the joint, if you did that too, right? 01:18PM

A. Yes. 01:18PM

Q. Request 18 says, "When Harvey arrived at BVH on November 8, (sic) his right front ankle was swollen 01:19PM

and he was lame. 01:19PM

Is that because the notes say only slightly lame? 01:19PM

A. I believe so. 01:19PM

Q. Okay. 01:19PM

A. Yeah. It's -- 01:19PM

Q. Lawyers do mince words from time to time. I'm guilty of it myself. 01:19PM

A. Yeah. I believe it was under notes. Yeah. No significant lameness observed on the 8th. 01:19PM

Q. Now, you -- when you saw him on the 29th, you saw -- 01:19PM

A. He was lame. 01:19PM

Q. Grade 3? 01:19PM

A. Uh-huh. 01:19PM

Q. And that's three out of five? 01:19PM

A. Three out of five. 01:19PM

Q. So that's more lame than not? 01:19PM

A. Yeah. 01:19PM

Q. That's very lame? 01:19PM

A. Five is not putting weight on it. One is you can barely pick it up and trot. So yeah. 01:19PM

Q. Okay. And then there was a -- and we don't need to find it right now. I'll find it later. But Dr. Mosley assessed him at a point in time at a Grade 2. 01:20PM

Do you remember that or no?

A. It may have been when he first came in. 01:20PM

Q. That would be slightly less lame? 01:20PM

A. Yeah. Yeah. 01:20PM

Q. Yeah. It was exactly that. On the 20th she assessed him at Grade 2 lameness -- 01:20PM

A. Uh-huh. 01:20PM

Q. -- on right forelimb. 01:20PM

That doesn't surprise you, right? 01:20PM

A. After sustaining an injury, no. 01:20PM

Q. But if anything, the fact that on the 8th he wasn't showing significant lameness, that made it just more mysterious, right? 01:20PM

A. Just didn't read the textbook, yeah. Didn't follow. 01:20PM

Q. Did Judy ever ask you if Harvey had a joint infection or might get a joint infection? 01:20PM

A. Not that I remember, but then again, she probably asked me why I wanted to refer, so I'm sure it probably came up. 01:20PM

Q. The reason is I just looked at on Page 5, Request 19. I guess that's because you didn't see him on November 8th probably as much as anything? 01:21PM

A. Yes. 01:21PM

Q. And that's fair enough. 01:21PM

Request 21 says, "On November 8th, 2013, no one at BVH took a sample of joint fluid from Harvey's right front ankle joint." That was denied. Now, I did not see anybody taking a sample. 01:21PM

A. No. That should have been -- 01:21PM

Q. Nobody took one? 01:21PM

A. -- approved. 01:21PM

Q. Well, we can let Mr. Goldsmith deny -- or decide how he should answer it, but as a matter of fact, so far as you know, nobody took -- 01:21PM

A. No, there is nothing -- 01:21PM

Q. -- joint fluid ever -- 01:21PM

A. -- in the record, no. 01:21PM

Q. Okay. On Page 6, Request 25 talks about the visit on the 29th. Says "he had a badly swollen right ankle joint and was Grade 4 lame." That should be Grade 3 lame? 01:21PM 01:22PM 01:22PM

A. Three. So just change it to three. 01:22PM

Q. Got it. 01:22PM

Was there ever a time when you told Judy Santerre that you did not think Harvey had a joint infection? 01:22PM

A. No. 01:22PM

Q. Request 30 says, "On November 29, (sic) no one at BVH administered local antibiotics to Harvey." 01:22PM

Do you see that?

A. Yeah. I did. I put a wrap on with antibiotics. It's just topical or local. 01:22PM

Q. That's the Furazone sweat? 01:22PM

A. Yes. 01:22PM

Q. But that was not anything designed to -- 01:22PM

A. It was not like an IV or anything. 01:22PM

Q. Okay. And it wasn't like the SMZ tablets even? 01:22PM

A. No. 01:22PM

Q. Furazone DMSO sweat. Okay. 01:22PM

On the next page Request 32 says, "A sweat wrap is contraindicated for treatment of a joint infection in a mature horse," and that was denied. 01:23PM

Is there authoritative literature that speaks to that? 01:23PM

A. I guess used correctly just for a 12-hour period to reduce inflammation I didn't think was contraindicated. That's why I denied that. 01:23PM

Q. Okay. But on a long-term basis, it wouldn't be a good thing, right? 01:23PM

A. No, no. Yeah. You couldn't keep doing it. My thought was using the topical to draw to get him comfortable -- at least a little more comfortable until his referral. 01:24PM

Q. Okay. 01:24PM

A. But long-term, you're right, that would be bad to continue sweating a horse with an infection. 01:24PM

Q. During the time that you were at Bastrop, prior to the time you saw Harvey, about what percentage of your work was with small animals and what with large? 01:24PM

A. Probably about 70 to 80 small and 10 to -- you know, 20 to 30 large, but then a lot of large was cattle too. We did cattle and horses. 01:24PM

Q. As between cattle and horses, how did that break down? 01:24PM

A. Maybe 10 percent horses, 20 percent cattle, something like that, of the 30. 01:24PM

Q. Got you. Okay. So one-third/two third basically? 01:24PM

A. Probably. 01:24PM

Q. And then how about during the time after you treated Harvey, was it about the same? 01:25PM

A. I would say the same. 01:25PM

Q. And how about at Wharton? 01:25PM

A. At Wharton, probably we do more cattle and horses. So I would say I probably do 60 percent small, 30 percent cattle, 10 percent horses. 01:25PM

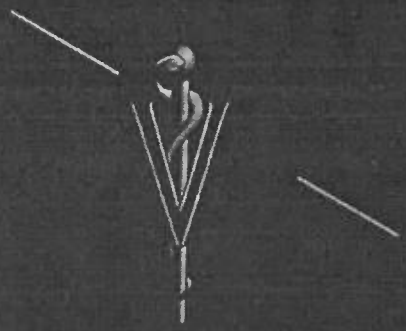
Q. Are you or have you ever been a horse owner yourself? 01:25PM

A. I have not. 01:25PM
Q. You look too smart for that. 01:25PM
A. I have had cattle -- or do have cattle. 01:25PM
Excuse me. 01:25PM
Q. I asked kind of as a precursor to asking you 01:25PM
if you have looked at any of the information concerning 01:25PM
valuing Harvey, that is how to determine what his value 01:25PM
was. 01:25PM
Have you looked at any of that? 01:25PM
A. I have not. 01:25PM
Q. Do you consider that you would be in a 01:25PM
position yourself to evaluate any of that? 01:26PM
A. No. 01:26PM
Q. Okay. 01:26PM
MS. ALLEN: Why don't you give me five 01:26PM
minutes. 01:26PM
MR. GOLDSMITH: Just to look over -- 01:26PM
MS. ALLEN: Yeah. 01:26PM
MR. GOLDSMITH: -- see where we're at? 01:26PM
That's fine. Go off the record. 01:26PM
(Recess from 1:26 p.m. to 1:33 p.m.) 01:26PM
(Exhibit 32 marked) 01:33PM
Q. (BY MS. ALLEN) Dr. Lucy, we're almost done. 01:33PM
Just a little bit of housekeeping here. 01:33PM
A. Okay. 01:33PM

Manual of Equine Emergencies

Treatment and Procedures

Second Edition



James A. Orsini
Thomas J. Divers

SAUNDERS

procedure. *Delay the procedure if periarticular cellulitis is present. Do not place a needle through a contaminated wound.* If signs of severe inflammation are present, treat for possible iatrogenic infection and lavage the joint.

Needle breakage is more likely in proximal joints when long, small-gauge needles are used. The needle often is difficult to retrieve if the horse is standing. Use flexible needles (spinal needles) that bend rather than break. Adequate patient restraint minimizes this complication.

CAUTION: Anesthesia of the proximal limb can result in loss of motor function and stumbling. The distal limb should be wrapped to prevent abrasions, and patients should be confined to a stall immediately after the examination.

24 Arthrocentesis and Synovial Fluid Analysis

James A. Orsini and Christine Kreuder

Analysis of the synovial fluid from a joint or tendon sheath can be useful in differentiating diseases that affect these structures. Synovial fluid is an ultrafiltrate of plasma, and pathologic conditions of synovium-bathed structures are reflected in the fluid. Aspiration of synovial fluid from joints and tendon sheaths requires familiarity with the applied anatomy. Patient restraint and strict adherence to aseptic technique are essential for safe arthrocentesis.

Equipment

- Sedative (xylazine hydrochloride and butorphanol tartrate)
- Twitch
- Clippers
- Material for sterile scrub
- Sterile gloves
- Needles (18-22-gauge) and 5-20-ml syringe (not Luer-Lok); see Figs. 23–4 through 23–10 for needle size required for each joint. Needles and syringes should be kept sterile throughout the procedure.
- 25-gauge needle, 3-ml syringe, and 2% local anesthetic if anesthesia of skin is desired
- EDTA and plain Vacutainer tubes*
- Culture material (Port-a-Cul,† blood culture bottles‡)

Procedure

- Clip or shave the site for arthrocentesis. Sites for arthrocentesis are identical to the sites for intraarticular anesthesia in Figs. 23–4 through 23–10.

*Vacutainer tubes. Becton-Dickinson Vacutainer Systems, Rutherford, NJ 07070.

†Port-a-Cul culture swab and transport system. Becton-Dickinson Microbiology Systems, Cockeysville, MD 21030.

‡Septi-check, BB blood culture bottle. Roche Diagnostic Systems, Indianapolis, IN 46256.

CAUTION: Do not place the needle through an open or contaminated wound or an area of possible infection. Determination of joint involvement after trauma or infection often requires alternative needle placement if the usual site for joint access is contaminated in any way.

- Sedation is optional. Recommended dosage for adults: 0.3-0.5 mg/kg xylazine with 0.01-0.02 mg/kg butorphanol IV. For neonatal foals: 0.1-0.2 mg/kg diazepam IV slowly.
- Place twitch.
- Perform a sterile scrub of the puncture site and any landmarks to be palpated.
- If the joint requires a 20-gauge or larger needle, place a bleb of 2% local anesthetic subcutaneously using a 25-gauge needle.
- Wearing sterile gloves, detach the needle from the syringe and place the needle with a rapid stick through the skin. Care must be taken not to damage the articular cartilage with the needle. Successful needle placement results in synovial fluid at the hub of the needle. Fluid may flow freely (particularly if the joint is distended), or it may have to be aspirated with a syringe. Digital pressure on other aspects of the joint usually increases the flow of fluid from the needle.

Failure to obtain synovial fluid often is caused by placement of the needle within or adjacent to a ligament, cartilage, or synovial lining. Attempt to redirect or rotate the needle without exiting the skin. The needle may also become plugged with tissue during placement. If synovial fluid is not obtained after the needle is redirected, attempt arthrocentesis with a new needle.

- Collect the sample into a plain tube for culture and an EDTA (purple top) Vacutainer tube for cytologic examination. Samples may be transported in the syringe used for collection: remove air and cap with a sterile needle. If the culture sample is not to be processed within 12 hours, place the sample in a blood culture bottle or Port-a-Cul transport system.

SYNOVIAL FLUID ANALYSIS

Color, clarity, volume, and viscosity of fluid collected are parameters immediately assessed. Normal synovial fluid is clear, slightly yellow, and completely free of particulate. Red streaks indicate trauma and bleeding caused by the needle during placement or aspiration. A uniform red or amber tinge may be caused by chronic intraarticular injury. An increase in turbidity or a dark yellow color is caused by inflammation. The presence of particles or purulent material indicates serofibrinous inflammation, which is often associated with infection (septic arthritis or tenosynovitis).

Viscosity is directly related to the amount and quality of hyaluronic acid secreted by the synovial membrane. Depolymerization or dilution of hyaluronate from inflammation causes a decrease in viscosity. Viscosity is assessed subjectively by means of placing a drop of fluid between the thumb and a finger; normal fluid strings out approximately 2-5 cm before breaking. Fluid expressed from a syringe also should form a string approximately 5-7 cm long.

Other important parameters are complete white blood cell count and differential. A slide preparation is made with a drop of the synovial fluid and a drop of Wright stain. The quantity, type, and state of degeneration of the white blood cells are useful for characterizing the inflammation. Total protein level quantifies the

TABLE 24–1. Correlation Between Synovial Fluid Parameters and Intraarticular Disorders

Condition	Appearance	Viscosity	Volume	Total Protein (g/dl)	Nucleated Cells/L	Cytologic Findings	Glucose (mg/dl)
Normal	Light yellow, clear	High	Low	<2.0	<0.4 x 10^9	<20% neutrophils	Equal to blood
Nonseptic synovitis	Yellow, translucent	Low	Generally increased	<3.0	2-10 x 10^9	>75% neutrophils (preserved)	25-50 mg/dl; lower than blood
Septic arthritis	Yellow-green, turbid	Low	Increased	3.0-6.0	30-100 x 10^9	>90% neutrophils (degenerate) with or without intracellular bacteria	<25 mg/dl
Degenerative joint disease (osteoarthritis)	Yellow, clear	Low (variable)	Low	<2.5	0.2-2 x 10^9	10%-30% neutrophils (preserved)	Equal to blood

degree of inflammation. Normal synovial fluid does not clot because it lacks fibrinogen and other clotting factors present during inflammation. Glucose concentration in synovial fluid is compared with serum concentration and may be decreased owing to consumption by inflammatory cells and bacteria. A Gram stain and culture are essential if a septic process is suspected. Negative culture results do not rule out infection; bacteria are isolated in only 50% of samples. Polymerase chain reaction has not been uniformly beneficial to identify pathogens in suspected cases of septic arthritis.

Table 24–1 shows the correlation between synovial fluid parameters and specific equine joint disorders.

Complications

See complications of intrasynovial anesthesia, p. 103.

25 Temporomandibular Arthrocentesis

James A. Orsini

Synovial fluid can be obtained from the temporomandibular joint (TMJ) by means of arthrocentesis. Analysis of synovial fluid is useful for determining the pathologic features of disease in this region. Arthrocentesis also can be used to administer intraarticular medications or to perform intrasynovial anesthesia.

NOTE: The following descriptive procedure has not been studied in foals or in young horses that have not reached mature bone growth. Anatomical variations in the growing horse may not correlate directly with the following description to identify the TMJ.

Equipment

- Sedative (IV detomidine hydrochloride)
- Clippers
- Sterile scrub materials (povidone-iodine and alcohol)
- 20-gauge, 1.5-inch (3.8-cm) needles and syringes (3, 6, or 12 ml)
- EDTA and plain Vacutainer tubes
- Culture material

Procedure

- Clip an area bordered by the lateral canthus of the eye and the base of ear and from the facial crest to the zygomatic process of the temporal bone.
- Sedate patient.
- Scrub the area to be injected.
- Maintain aseptic technique.
- Palpate the TMJ by placing one finger on the lateral canthus of the eye and another finger at the base of the ear. With the middle three digits flexed, the third digit marks the lateral portion of the mandible (Fig 25–1).

Q. One of the excerpts from the Divers book that I didn't show you is Exhibit 32 and it has to do with synovial fluid, drawing it, analyzing it and that sort of thing. 01:33PM 01:33PM 01:34PM 01:34PM

You're familiar with the generally accepted -- 01:34PM 01:34PM

A. Procedure? Yes. 01:34PM

Q. -- procedure for that? 01:34PM 01:34PM

And the Divers book describes the generally accepted procedure for that, right? 01:34PM 01:34PM

A. Yes. Or (indicating). 01:34PM

Q. And he states that you can't -- basically that you can't really ever know what you're dealing with when it comes to synovial fluid -- joint fluid unless you draw it out and examine it, is that correct? 01:34PM 01:34PM 01:34PM 01:34PM 01:34PM

MR. GOLDSMITH: What part are you looking at? 01:34PM 01:34PM

MS. ALLEN: I'm summarizing that -- 01:34PM

MR. GOLDSMITH: Okay. 01:34PM

MS. ALLEN: -- and seeing if she agrees that that is correct. 01:34PM 01:34PM

A. Can you reword that or repeat the question? Excuse me. So this goes over how to do it. Is that what you're saying? 01:34PM 01:34PM 01:34PM

Q. (BY MS. ALLEN) That goes over how to -- 01:34PM

A. Perform it. 01:34PM

Q. -- extract it and how to analyze it. 01:34PM

A. Yes. 01:34PM

Q. And to some extent what it tells you when you do analyze it -- 01:34PM

A. Yes. 01:35PM

Q. -- correct? 01:35PM

A. (Nods affirmatively.) 01:35PM

Q. And to perform procedures like gram stains and those types of procedures are, in his words, essential, isn't that right? 01:35PM

A. Yes. To diagnose a joint infection, you need to look at a sample. 01:35PM

Q. And his view, which is the generally accepted view, is that you really can't reliably diagnose a joint infection without taking a sample, isn't that true? 01:35PM

MR. GOLDSMITH: Don't answer the question until you read through it and confirm the statement. 01:35PM

A. (Reviewing document.) So -- so from what I get from this is that, yes, as we've been talking all along, this is one of the forms -- one of the steps, diagnostics that can be useful to diagnose a joint infection. 01:35PM 01:36PM 01:36PM 01:36PM

Q. (BY MS. ALLEN) Is there any way that you know of besides the steps that are outlined in this segment 01:36PM

of Divers' treatise to confirm one way or the other whether or not you're dealing with a joint infection? 01:36PM

A. No. 01:36PM

Q. This is it, right? 01:36PM

A. This is the way to diagnose if you see bacteria, you see neutrophils, those type things. 01:36PM

Q. And he has somewhere in here -- and I've forgotten where it is -- he tells us the range of neutrophils that you would expect to see with the septic joint, right? 01:36PM

A. So greater than 90 is what he diagnoses as septic. 01:36PM

Q. And Harvey's was 98, right? 01:37PM

A. Yes. Oh, I believe. 01:37PM

Q. On the 4th of September, correct? 01:37PM

A. Yes. 01:37PM

MR. GOLDSMITH: Objection, form. 01:37PM

Q. (BY MS. ALLEN) Well, that's what A&M reported, wasn't it? 01:37PM

MR. GOLDSMITH: 4th of December, not 4th of September. 01:37PM

MS. ALLEN: I'm sorry. You're exactly right. 01:37PM

A. Yes. 01:37PM

Q. (BY MS. ALLEN) Mr. Goldsmith corrected it and 01:37PM

I want the record to be correct. You and I were mistaken -- I was mistaken. It was the 4th of December he went to A&M? 01:37PM

A. Yes. 01:37PM

Q. The Divers tests were run and it was determined that the neutrophil level was 98 percent, correct? 01:37PM

A. Percent. Yes. 01:37PM

Q. And that, according to the Divers treatise, is septic arthritis or a joint infection, correct? 01:37PM

A. Yes. 01:37PM

Q. And you don't believe that happened overnight, do you? 01:37PM

A. No. 01:37PM

Q. That had been working up to that level, had it not? 01:37PM

A. Yes. 01:37PM

Q. You just don't know when it started, do you? 01:37PM

A. No. 01:37PM

Q. It could have started as early as September 20, isn't that right? 01:37PM

MR. GOLDSMITH: Objection, form. 01:38PM

A. There's no way to tell when it started. 01:38PM

Q. (BY MS. ALLEN) But it could have started as early as September 20 -- 01:38PM

MR. GOLDSMITH: Objection, form. 01:38PM

Q. (BY MS. ALLEN) -- when the laceration -- 01:38PM

A. It's a possibility, sure. 01:38PM

Q. Okay. If -- how could we -- let me back up a minute. 01:38PM

You would agree that if proper and accepted procedures for the diagnosis and treatment of the joint infection are performed within 24 hours of a traumatic injury over a synovial structure, then the prognosis is very good -- prognosis for recovery is generally very good? 01:38PM 01:39PM 01:39PM 01:39PM

MR. GOLDSMITH: Objection, form. 01:39PM

A. Yes. 01:39PM

Q. (BY MS. ALLEN) And that the longer you delay the proper diagnosis and treatment, the -- the worse the prognosis becomes? 01:39PM 01:39PM

A. Yes. 01:39PM

Q. And that's just for the limb that's involved with the septic problem, right? It doesn't count the support limb problem, correct? 01:39PM 01:39PM

A. Can you reword that? Sorry. 01:39PM

Q. Yeah. It wasn't very -- 01:39PM

A. Or repeat it. 01:39PM

Q. It wasn't very articulate. 01:39PM

A. No. 01:39PM

Q. We talked about the prognosis of treatment and diag- -- diagnosis and treatment are done right away. 01:40PM

A. True. 01:40PM

Q. If accepted practices for diagnosis and treatment of wound over a synovial structure like Harvey's are not done right away, then the prognosis worsens, isn't that true? 01:40PM

A. Yes. 01:40PM

Q. And the longer that the delay continues, the more it worsens, isn't that true? 01:40PM

A. Yes, it can. 01:40PM

Q. Would you agree that the treatment that was given at the Bastrop Veterinary Hospital did not follow the steps that are outlined in the Divers treatise? 01:40PM

A. Yes. 01:40PM

MS. ALLEN: I don't have anything else for you at this time. Thank you so much, Doctor. 01:40PM

THE WITNESS: You're welcome. 01:41PM

MR. GOLDSMITH: We'll reserve our questions for the time of trial. 01:41PM

(Deposition concluded at 1:41 p.m.) 01:41PM

CHANGES AND SIGNATURE

WITNESS NAME: LUCY PUSTEJOVSKY, DVM

DATE OF DEPOSITION: FEBRUARY 29, 2016

PAGE	LINE	CHANGE	REASON

I, LUCY PUSTEJOVSKY, DVM, have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted above.

_____

LUCY PUSTEJOVSKY, DVM

THE STATE OF _____)
COUNTY OF _____)

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

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

_____

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

CAUSE NO. 087-21

JUDY SANTERRE, Plaintiff VS. BASTROP VETERINARY HOSPITAL LARGE ANIMAL SERVICES, P.C., DR. JEFFERY SCHROEDER, DVM, DR. DARREN WEISS, DVM, DR. STEFANIE MOSLEY, DVM, AND DR. LUCY PUSTEJOVSKY, DVM, Defendants	IN THE DISTRICT COURT BASTROP COUNTY, TEXAS 21ST JUDICIAL DISTRICT

REPORTER'S CERTIFICATION
ORAL DEPOSITION OF
LUCY PUSTEJOVSKY, DVM
February 29, 2016
Volume 1

I, Julie A. Jordan, Certified Shorthand Reporter in and for the State of Texas, hereby certify to the following:

That the witness, LUCY PUSTEJOVSKY, DVM, was duly sworn by the officer and that the transcript of the oral deposition is a true record of the testimony given by the witness;

That the deposition transcript was submitted on _____ to Mr. James W. Goldsmith, Jr., attorney for the Defendants, for examination, signature and return to me by _____;

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

Ms. Kathryn E. Allen - 02 Hour(s):49 Minute(s)
Mr. James W. Goldsmith - NONE

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

Ms. Kathryn E. Allen, Attorney for Plaintiff
Mr. James W. Goldsmith, Attorney for Defendants

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

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

Certified to by me this 3rd day of March, 2016.

Julie A. Jordan

Julie A. Jordan, Texas CSR 3203
Expiration Date: 12/31/17
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FURTHER CERTIFICATION UNDER RULE 203 TRCP

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

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

If returned, the original deposition was delivered to Ms. Kathryn E. Allen, Custodial Attorney;

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

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

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

_____
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