Q. And what else did you do?
A. My technician measured her vision and that's about all. Let me look at the original record also to be sure there isn't anything else. Yes, that's all. Everything looked perfect. I told her to come back.
Q. That was my next question: How was she doing? Did you do any refraction that day?
A. I doubt it. No. We never refract on the first day. There was an automated refraction and I'm not sure which date that was. No. I didn't personally refract her. I'm not sure whether that automated refraction goes with that date or the one after, probably the one after.
Q. Which would be the 3/24?
A. Yes.
Q. What you saw on that day -- are the results that you saw what you would expect to see the day after the procedure was performed?
A. Yes.
Q. Did you note at that point any decentration of the right eye?
A. There was no way I would have known it if there had been one. I didn't note anything. The eye looked fine but the only way we could tell decentration would be topography.

Q. Okay. The topography was next done on the 24th?
A. I should have brought the original records. It's very difficult to give -- I can give some opinions on them but without the color --
MS. POST: Since you didn't see her on the 24th, I think we have to wait for a question.
THE WITNESS: Right.
BY MR. KAFRISSEN:
Q. This is what I have been provided. There's two shots, it looks like, of the 3/24/97 topography?
A. Yes. These are two different kinds of topography.
Q. Can you tell me what they are.
A. The one on the left is an elevation map, which tells the relative height of the cornea, and the one on the right is a curvature map, which measures the degree of curvature in different parts of the cornea. It is derived from the elevation. It is a secondary derivation.
Q. And do those show the decentration?
A. They show -- the ablation shows some decentration, a small amount, yes

MS. NEWMAN: What date are you on?
MR. KAFRISSEN: The 3/24/97 topography.
THE WITNESS: I must make clear something. There is a difference between decentration of the laser ablation and pre-existing irregularities of the cornea.
BY MR. KAFRISSEN:
Q. Okay.
A. And this picture done the next day shows the net interaction of the laser and the cornea. In other words, if she had pre-existing irregularity, that might show some decentration even if the laser centration was absolutely perfect.
Q. Okay. Are you aware of any pre-existing irregularity?
A. Yes. Her cornea was not a billiard ball, so to speak, prior to surgery. It had some irregularity, and I have a feeling that while some of this decentration may be from her not looking at exactly the right centration point, most of it is probably due to her own pre-existing corneal status, since the subtraction picture here shows excellent centration of the laser beam itself with her optical axis.
Q. And just tell me which -- the subtraction

you're referring to is the one --
A. Of 5/12/97.
MS. NEWMAN: And when you say that some of it might be as a result of her not looking at the centration beam...
THE WITNESS: That's possible also.
MS. NEWMAN: ...are you referring to the Plaintiff, to Miss Fiorelli?
THE WITNESS: Yes, I'm referring strictly to the Plaintiff. There are two factors in centration which maybe I didn't make clear.
BY MR. KAFRISSEN:
Q. Okay.
A. I can see that the laser is centered, and that means that the ablation will be placed exactly where the surgeon aims it, but then Miss Fiorelli, or whatever patient is lying there, has to be looking directly at the fixation light, which is located in the center of the ablation beam, and if she is not looking right at the light, then she might get some decentration anyhow, and we instruct every patient very carefully to look exactly at the light.
Q. Okay.

A. And most of them follow instructions but not all.
Q. Is there any indication in the record or in the notes that Cheryl was not looking at the light?
A. There's no way we could know. We have to tell her what to do and then we can only tell by the topography whether her optical axis was indeed lined up with the laser beam center.
Q. Okay. Now, did you note on March 21 that there was any degree of overcorrection?
A. I didn't make a note of it but there is expected to be a degree of overcorrection, especially with such a high correction.
Q. What, given the high correction, would you expect to be an acceptable degree of overcorrection?
A. It varies. There is no acceptable degree for the first few days or even the first few weeks. Everyone is overcorrected, and usually we don't even measure the refraction immediately after. We let things simmer down for a few weeks.
Q. Okay. After a few weeks, is there an amount of overcorrection which continues to be acceptable?
A. Well, we would like, ultimately, her over-correction to be within a diopter or so, but it might

take as long as three months. At the end of three months, we would feel she's overcorrected if she is significantly hyperoptic more than the diopter.
Q. Can you tell me what is the cause or causes of overcorrection in a Lasik procedure?
A. There are many possible causes. The humidity level of the room could vary and if there's evaporation, the cornea becomes more compact and you get over-correction. Our nomograms, on which we base the amount of correction to be done, are based on averages: average amount of humidity and average length of time. And if the flap is left open an excessively long time, there will be more drying and that can give you overcorrection. And some people's tissue varies. Everyone's varies, actually, and some people just have more tissue ablated than other people, depending primarily on the hydration of their tissue, but there are other reasons. Some people react more and some less. This is an average.
Q. Okay. Can the removal of too much tissue by the surgeon result in overcorrection?
A. Removal of too much tissue is the cause of the overcorrection. In other words, drying allows too much tissue to be removed if the laser beam is stronger than it should be, that would allow too much tissue. That