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State of Ohio,)
) SS:
County of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

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Thomas J. Ortman, et al.,	)	
	)	
Plaintiffs,	)	
	)	
vs.	)	Case No. 317279
	)	Judge Christopher
Robert Alberhasky, M.D., et al.,	)	Boyko
	)	
Defendants.	)	

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DEPOSITION OF ROBERT ALBERHASKY, M.D.

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Deposition of ROBERT ALBERHASKY, M.D., called by the Plaintiffs for examination pursuant to the Ohio Rules of Civil Procedure, taken before Phyllis L. Englehart, RMR and Notary Public in and for the State of Ohio, at Meridia Huron Hospital, 13951 Terrace Rd., Cleveland, Ohio, on Tuesday, May 20, 1997 commencing at 1:55 p.m.

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I N D E X

Witness	Cross
Robert Alberhasky, M.D.	4

- - -

E X H I B I T S

Plaintiffs'	Marked
1	4
2	18
3	34
4	34
5	42
6	49
7	52
8	52

APPEARANCES:

On Behalf of the Plaintiffs:

Jack Landskroner
Landskroner & Phillips
55 Public Square, Suite 1040
Cleveland, Ohio 44113

On Behalf of Defendants Dr. Alberhasky and Dr. Basa:

Marilyn J. Miller
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue, Suite 1600
Cleveland, Ohio 44114

On Behalf of Defendants Dr. Laye and West Side Imaging and Oncology:

John Polito
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue, Suite 1600
Cleveland, Ohio 44114

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ROBERT ALBERHASKY, M.D.

having been first duly sworn, as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION

By Mr. Landskroner:

Q Doctor, will you state your name for the record, full name and address, please.

A Robert Alberhasky, A-L-B-E-R-H-A-S-K-Y. My home address is **10221** Lake Shore Boulevard, Bratenahl, Ohio **44108**.

(Plaintiffs' Exhibit 1 marked for identification)

Q Doctor, I'm going to show you what's been marked Plaintiff's Exhibit 1 and ask if you can identify that for me, please.

A Yes. This is my CV.

Q And it's up-to-date?

A Yes, it appears to be.

Q Today I'm going to be asking you some questions in the matter of Tom Ortman versus Dr. Basa, Dr. Laye, Dr. Alberhasky. I'll ask you some questions about your history, about your employment, about the treatment and care of Mr. Tom Ortman.

If at any point in time I ask you a question which you don't understand, please stop me,

ask me to rephrase the question. I want to make sure you only give answers to questions that you understand. Please make your responses verbal so the court reporter can take everything down.

A Yes.

Q Doctor, in looking at your CV, I'm just going to run through this real quick with you so we won't take a lot of time on it, but you did your medical school at University of Louisville?

A That's correct.

Q I noted in your answers to interrogatories that you were licensed in Kentucky through, I believe, 1980; is that correct?

A In Kentucky you have a current license as long as you're practicing there and then --

MS. MILLER: Doctor, yes or no, was it 1980?

A 1980, yes.

Q Do you maintain that license in Kentucky?

A No.

Q Why is it you no longer maintain that license?

A It's currently inactive as accords Kentucky statute.

Q Presently you are licensed in the state of Ohio?

A Yes.

Q Are you licensed in any other states?

I have a pending application in Maine.

Q When did you apply for that application?

I believe it was in fall of last year.

Q What's the purpose for applying for the Maine application?

I'm considering relocating if another job opportunity presents itself.

Q Have you ever been denied application for any state?

No.

Q Do you maintain more than one version of your curriculum vitae?

MS. MILLER: Does that include an older one or updated one?

Q In terms of one for professional organizations, one for speaking engagements.

No.

Q I note that you have some publications on your CV. Do any of these publications deal with the issues that are presented in the Ortman case?

No, not specifically.

Q I note that many of the versions deal with carcinoma but not specifically germ cell or seminoma?

That's correct.

Q Doctor, are you board certified?

Yes.

Q Was that certification obtained in 1980?
A Yes
Q Have you been recertified?
A No.
Q When are you required to be recertified?
A I'm not required by my professional board to be recertified.
Q That is the American Board of Pathology?
A Yes.
Q Can you tell me what you must go through to become board certified in pathology?
A There's a course of residency training. At the time that I went through residency, it was generally a four-year program After successfully completing a pathology residency, you take a board examination, and that's the procedure.
Q Did you pass your board examination on the first try?
A Yes.
Q Is there a written and an oral section to that board?
A There is no oral
Q What is the College of American Pathology?
A It is a professional organization that pathologists may join

Q What is a laboratory inspector? I note that's your designation for that college.

A I'm involved occasionally in helping inspect other laboratories and see that they are following the recommendations and complying with the national guidelines for laboratory services.

Q What are the national guidelines for laboratory services?

A That can't be simply answered.

Q Is there a set, I guess grouping of books or literature that set forth standards that have to be adhered to?

A There's hundreds of pages.

Q Is there a designation to what that's called, all the pages?

A The joint commission has a set of standards and regulations that apply to hosp tals. There are particular things that apply to the laboratory and quality control and things like that.

Q Does that deal with the operation of the laboratory, or does that carry over into the actual practice of medicine?

A It involves everything.

Q Doctor, have you ever testified as an expert in a lawsuit, either for the plaintiff or the defendant?

MS. MILLER: Objection.

A In residency -- I guess the answer would be yes.

Q Can you tell me about where and when and how you did that?

A It was through the board of medical examiners in Kentucky. I was involved with the medical examiners department as part of my training and residency, and on numerous occasions I was called into court to testify as to results of autopsies and things like this.

Q Have you ever testified in a medical-legal issue related to a civil lawsuit?

A No.

Q Have you ever been named as a defendant in a lawsuit?

MS. MILLER: Objection.

A Yes.

Q Can you tell me when you were named as a defendant in a lawsuit?

MS. MILLER: Rather than interrupt, I'm just going to show a continuing objection to this line of questions.

MR. LANDSKRONER: Noted.

A I can't give you specific dates.

Q Can you tell me the names of any of the cases that

you were involved in?

A I'm not familiar with the names.

Q Can you tell me how many times that you've been named as a defendant?

A Three, to my knowledge.

Q Can you tell me about the medical issues that were involved in those three cases?

A In one case I had seen a biopsy of a colon polyp. The patient died during surgery, and every physician's name on the chart was sued. Because I had issued a report that was on the chart, I was named in the suit. I was subsequently released from this.

Q Let me interrupt while you're talking about that case. Do you know if there was a settlement involved in your release from that case?

A I have no idea.

Q Okay. Go ahead, I'm sorry.

A The second case involved a woman who had fallen out of bed and broken her hip at Euclid Hospital. I had seen her uterus and determined that she had smooth muscle tumors of the uterus, and because my name was on the chart, I was again named in the lawsuit. But it was ascertained that I was not responsible for having anything to do with her supervision or care

while she was in the hospital beyond the interpretation of the surgical specimen that was removed from her, and so I was released from that case.

Q Do you know if you were released with any type of settlement?

Oh, there was no -- I mean there was no settlement on my part certainly.

Q Were you deposed in that case?

No.

Q Were you deposed in the first case that you mentioned?

No.

Q And the third incident?

The third incident involved a biopsy of the -- the third incident involved a case of clear cell carcinoma of the vagina that was initially interpreted as an inflammatory reaction, and subsequent history was obtained, and it was proven to be a clear cell carcinoma. There was no settlement in this case.

Q Are any of these cases still ongoing?

No.

Q Was your deposition taken in that cas ?

I don't remember.

Have you had your deposition taken before today?
Yes.
Q Can you tell me the circumstances in which it was taken?
In the context of surgical specimens which I had reviewed and which were being examined in other cases.
Q I assume you were deposed as a treating physician in the other cases, someone who had reviewed --
I was being deposed as someone who had provided information in another case. I have not been deposed -- I don't remember whether I was deposed in the case that involves clear cell carcinoma.
Other times I've been deposed it's been in things that are related to surgical specimens that I looked at at the hospital, and I don't really know what the cases were about or who the physicians were involved. I was just asked to render an opinion or answer some questions involving a service that I had provided.
Q Does the case Karpi versus Euclid General Hospital ring a bell?
Karpi is the case that I had described to you.
Q Which one? That was the biopsy of the cervix?
This was the one where there was a biopsy.

Actually, it was a biopsy of the vagina.

Q Is that the case that you were unaware of whether there was any settlement involved?

A I'm not aware that there was a settlement involved in that case. I do not believe that there was.

Q Are you aware that Euclid General Hospital in that case filed a claim against you as well?

MS. MILLER: Objection,

A No, I was not aware of that.

Q So I'm clear, in none of the cases that you were named as a defendant was there any settlement that you're aware of with regard to your actions?

A That's correct.

Q And did you at any point in time testify in court related to any of these cases?

A No.

Q Doctor, according to your CV, you are presently employed by Bayless-Pathmark, Inc., Smith-Kline Beecham Laboratories, correct?

A No. I am currently employed by Bayless-Pathmark. I am no longer involved with Smith-Kline.

Q Are those separate entities and you did work for both at one point?

A Bayless-Pathmark provides pathology services to a number of different entities, and the individual

pathologists are rotated between these entities at various times. I had an assignment at Smith-Kline Laboratory, and I'm currently assigned to hospitals within the Meridia system.

Q In March of 1995 through December of 1995, you were involved with Bayless, and were you assigned out to Southwest General Hospital?

A From when?

Q Looking at your CV, March 1995 to December 1995 it was --

A I was at Southwest General, yes.

Q That's under the same circumstances, Bayless sent you out to work at Southwest?

A That's correct.

Q Can you tell me what your relationship at that time was with The Surgery Center?

A The physicians and the pathology group at Southwest General also provided services to The Surgery Center that was across the street from the hospital.

Q So that was part of your duties in working with Southwest?

A Part of my duties at Southwest was to rotate through The Surgery Center.

Q You are an employee of Bayless-Pathmark, Inc.?

A That's correct.

Q Do you have any financial ownership interest?
No.
MS. MILLER: Objection.
Q From July of 1981 through February of 1995, you were involved with Euclid General Hospital through Pathology Associates, Inc.?
That's correct.
Q Did Pathology Associates, Inc. become or get bought out by Bayless-Pathmark?
Yes.
Q At that time period, were you also working in any capacity at Lakewood Hospital?
No.
Q From your answers to interrogatories, you have hospital privileges at Meridia Euclid, all the Meridia hospitals?
Uh-huh.
Q And also Southwest General; is that correct?
I no longer have current privileges at Southwest General.
Q Did those privileges lapse, or was there any reason for --
They lapsed.
Q How about Firelands Community Hospital?
I was credentialed there, but I don't know the

current status of it because I'm no longer assigned to work there, and so I have no need to be on their staff.

Q. Have you, over the course of your years in Cleveland, been licensed, or rather have privileges at any other hospitals in the Cleveland community?

A. No, not outside the Meridia system.

Q. Do you maintain any other business pursuits outside of your practice of pathology through Bayless, Inc.?

A. Through Bayless?

Q. Outside of Bayless.

A. Outside of Bayless?

Q. Yes.

A. I own part of an apartment building.

Q. Okay. Anything else besides that in the medical realm?

A. No.

Q. Doctor, in your practice have you previously dealt, prior to dealing with Mr. Ortman's pathology, with cases involving seminoma?

A. Yes.

Q. Testicular seminoma?

A. Yes.

Q. Have you previously deal, with cases that have involved germ cell carcinoma?

A. Seminoma is germ cell carcinoma.

Q. I'm sorry. Embryonal carcinoma, sorry.

A. Yes.

Q. And have you previously dealt with patients who have had pathology of both, mixed cell carcinoma?

A. Yes.

Q. Can you tell me in the Cleveland community who you would consider to be an expert in the area of pathology dealing with those types of tumors?

MS. MILLER: Objection.

A. Howard Levin.

Q. He's a doctor who practices at the Cleveland Clinic?

A. Yes.

Q. Prior to your deposition today, did you have a chance to review any materials, aside from the pathology slides which I provided?

A. I haven't looked at anything specifically.

Q. Have you at any point gone back and looked through the medical chart of Mr. Ortman since the filing of this lawsuit?

A. I believe I saw some records when we had our initial interview. I don't know specifically what they were.

Q. I assume you've had a chance to take a look at your pathology findings from Mr. Ortman?

A Yes.
Q And also a consultation note as well?
A Yes.
Q There anything else that you're aware of that you helped to author as part of Mr. Ortman's chart?
A As part of his chart?
Q Yes. Anything else that you were involved in authoring that is part of his chart that you're aware of?
A That is part o his chart, no.
Q How about that's outside of his chart?
A There is a quality control sheet that referred to this case that was circulated amongst pathologists at Southwest General. That's the only other document, to my knowledge.

(Plaintiffs' Exhibit 2 marked for identification)

Q I show you what's marked Plaintiffs' Exhibit 2. Can you identify that for me?
A Yes. This is the quality control document that I referred to.
Q And how is it that this document was put together in terms of were you requested to fill this out in addition to your pathology finding?
A I left this case for a second opinion for another

pathologist.

Q Why did you do that?

A It's something we often do with cases that are interesting or are challenging or where we wish to have a second opinion.

Q In this case, why was it interesting or challenging?

A I wanted to see if someone would confirm my diagnosis of seminoma, and I wanted them to examine an area on the tunica, which is the capsule of the testicle, and I wanted to see if they agreed with me that this was a pickup and not a focus of invasion.

Q Explain to me as layperson the difference between a pickup and the focus of invasion.

A When slides are cut and tissue is prepared, fragments of tissue can become dislodged from where they naturally are and then appear on the slide in a slightly different area, and we determine this by looking at the plane and focus and see if they're in the same plane as the other tissue or if it's something that just doesn't belong where it is.

Those kind of pieces of tissue are referred to as pickups. Sometimes they come from the case itself. Sometimes they come from the tissue process or the water bath or from instruments that the technicians use in preparing slides.

Q Can those pickups affect the findings of the pathology?

A Yes, they can, if they're misinterpreted.

Q In this case, was there a pickup?

A Yes, there appeared to be a pickup.

Q And what were the findings of the pickup?

A It was thought to represent a fragment of tissue dislodged from the tumor and not tumor that was on the capsule of the specimen.

Q In terms of making a diagnosis, did that affect the diagnosis of this patient at all?

A No.

Q So I'm clear, this form is something that you initiated to have a second opinion formed?

A Yes.

Q I believe that KG is Dr. Karen Gerkin?

A That's correct.

Q Who is Dr. Karen Gerkin and what is her area of specialty?

A She is a pathologist at Southwest General.

Q Does she also do work at The Surgery Center?

A Yes, she does.

Q Is she still, to your knowledge, at Southwest General Hospital?

A Yes.

Q Does she have any position in the department at the hospital?

A I believe she's currently the chairman.

Q Did you consult with her in terms of this diagnosis beyond just leaving it for review? Did you talk to her about her findings?

A No, I did not.

Q If you will walk me through the process, you fill out this form and leave the form for the physician. The physician will then issue a follow-up opinion?

A She concurred with my diagnosis and released the report.

Q At any point in time did you talk to her about her findings?

A Not that I'm aware of.

MS. MILLER: Do you mean prior to the initiation of the lawsuit? Do you mean at the time this report was --

Q At any time after the report was rendered, have you talked to her about her findings?

A Yes, I have.

Q And tell me when you talked to her and what the essence of the conversation was.

THE WITNESS: Do you remember when we had our initial meeting? It was that day.

MS. MILLER: In January.

A It was in January. I told her that there was a case that I had been named in and that there was a quality control document where she had concurred with my diagnosis.

Q Anything else? What was her response in terms of that discussion?

MS. MILLER: Objection.

A I don't specifically remember.

Q Do you know if she went back and reviewed the pathology?

MS. MILLER: Objection.

A I do not know.

Q Have you asked her to become involved in this case in any way?

MS. MILLER: Objection.

A No.

Q Have you had any subsequent conversations with her?

A No.

Q How long did you work with this doctor?

A From March till December.

Q Had you ever worked with Dr. Gerkin before?

A No.

Q Do you have any social ties to Dr. Gerkin?

A No.

Q If you will, run through the language on the side under "Diagnosis" on the document. It's your handwriting. Is that your handwriting?

A Yes.

Q Can you tell me what that says?

A It says, "Seminoma tunica has pickup, not invasion."

Q Again, in terms of layman terms, what does that mean?

A Seminoma is malignant germ cell tumor, that was my diagnosis, and I made a comment that there was a piece of tumor on the capsule of the specimen that I thought represented a pickup or an artifact, not invasive tumor.

Q Do you know if Dr. Gerkin reviewed these findings in terms of just evaluating whether or not this was a pickup or whether she evaluated it in terms of concurring with your findings of the pathology in total?

A Well, I would believe that she concurs with my diagnosis, because that is what she has stated.

Q Doctor, have you discussed this case with any other physicians?

A No.

Q Do you know Dr. Basa?

A No.

Q Do you know Dr. Laye?
A No.
Q Do you know Dr. Tancinco?
A Yes.
Q Who is Dr. Tancinco?
A Dr. Tancinco is a pathologist who practices at Southwest General.
Q Was he there at the same time that you were there?
A Yes.
Q Do you know, is he still at Southwest General?
A I believe so.
Q Are you familiar with Dr. Fadi Abdul-Karim, F-A-D-I, A-B-D-U-L, K-A-R-I-M?
A Yes.
Q Do you know him in a professional capacity?
A Yes.
Q Dr. Karim is at University Hospital as a pathologist?
A That's correct.
Q Have you discussed with any of these physicians their findings in this case?
A No.
Q Doctor, can you define for me what is pathology?
A It's the study of disease.
Q Is there a distinction between different types of

pathology? I notice in your answers to interrogatories you mention anatomic versus clinical.

A. Specifically do you want to know the difference between anatomical and clinical pathology?

Q. Yes.

A. Clinical pathology is the study of disease by methods of laboratory examination. Anatomic pathology is the study of disease by the examination of tissues and cells that come from the body.

Q. Is it correct to say you work in both areas?

A. Yes.

Q. Is there a distinction in board certification --

A. Yes.

Q. -- as to the two areas? Are you board certified in both areas?

A. Yes.

Q. Just so I'm clear, you do not practice in areas of oncology, surgery or urology?

A. That's correct.

Q. Can you tell me how it is you came to become involved with the care of Mr. Ortman?

A. His surgical specimen came through The Surgery Center on the day when I was assigned there.

Q. Were you asked to review that specimen by one of

Mr. Ortman's physicians?

A Not specifically, but that is the general process of events.

Q If you can just sort of walk me through how it is that you came to get that specimen.

A I went to The Surgery Center, and there was a tray of slides for me to examine. And I looked at the slides and I looked at a gross description of the specimen that had been prepared by another physician, and I compared the slides and the gross report and rendered a diagnosis.

Q Your diagnosis was rendered in terms of a written report; is that correct?

A Yes.

Q At any point in time did you talk to any of the other care providers for Mr. Ortman about that report?

A No.

Q Did you ever meet Tom Ortman?

A No.

Q Have you ever spoken to Mr. Ortman or anyone in his family?

A No.

Q Are there any written guidelines or standards of practice that are published by any pathological

professional organization?

MS. MILLER: - Objection.

A Yes.

Q What are those?

A They are part of the same kind of general guidelines I would imagine as pertain to law. They are not specific. There's nothing that I could tell you briefly. I mean, you know, there are volumes up there.

Q What do you rely on as an authoritative treatise or publication in the area of pathology?

MS. MILLER: Objection.

Me personally?

Q Sure.

MS. MILLER: Objection.

I have a series of journals that I look at. I have dozens of books. I download information from the Internet.

Q Can you give me the names of the journals that you receive or some of them?

A I don't currently have subscriptions, but -- in my own name, but our department subscribes to probably a dozen journals that are available to us at the hospital and through the medical library.

Q Are there any that deal with specifically the issues

that are presented in this case?

MS. MILLER: - Objection.

Q On any regular basis or even an occasional basis?

A Many of them do.

Q If you can give me the names of a couple of the publications that you review.

MS. MILLER: Objection. Jack, he's told you there's numerous titles.

MR. LANDSKRONER: I'm just asking for a couple of them.

A Diagnostic Cytology, the American Journal of Clinical Pathology, Cancer.

Q What about in terms of a text that you rely on in your practice?

MS. MILLER: Objection. It's been asked and answered.

A Do you want me to select one at random?

Q Yes, just a text that you would rely on in your practice.

MS. MILLER: Jack, he said he relies on a couple of textbooks.

MR. LANDSKRONER: I'm asking for one he relies on.

A Anderson's General Pathology.

Q If you can, Doctor, will you define for me seminoma.

Seminoma is a germ cell tumor of the testicles.

Q What's anaplastic?

Anaplastic? Anaplastic is a term that refers to the appearance of cells, and it generally means that they're bad looking.

Q Nonseminomatous, is that a correct pronunciation?

Nonseminomatous.

Q Nonseminomatous germ cell tumor, what is that?

It's a germ cell tumor that's not a seminoma.

Q Does embryonal carcinoma fall into that category?

Yes.

Q What is an embryonal carcinoma?

It is another malignant germ cell tumor.

Q Can you tell me how it is different than a seminoma?

Okay. Seminomas are derived from germ cells, and they are considered to be the most undifferentiated form of a malignant germ cell tumor.

Tumors that are derived from germ cells that show other features of differentiation than seminoma may exhibit themselves as teratomas, as entodermal Steiner's tumors, as choriocarcinomas. You know, there's a variety of tumors that show differentiation that causes them to be classified differently.

Q Can you tell me what specifically distinguishes a

seminoma from an embryonal carcinoma?

A There's thought to be -epithelial differentiation.

Q Can you take me a step further? What do you mean by epithelial differentiation?

A Well, germ cells are the cells which in the male become sperm and which in women become the ova. Epithelium is the lining of the skin and the lining of different glands in the bodies. When the germ cell tumor -- since the germ cell tumor is part of the human reproductive process, these cells have the genetic code within them for duplicating the whole body, any part of the body.

When they show differentiation in terms of like skin or a glandular component or a neural component, that is in the form of epithelium, and so when the germ cell tumor is showing differentiation beyond that of seminoma, it may fall into one of these other categories.

Q Is shape something that you would see in terms of distinguishing a germ cell from an embryonal cell carcinoma?

A The shape of the cell?

Q **Yes.**

A The shape of the nucleus, the shape of the nucleolus, I'm not sure what --

Q Is there a distinction between any of them, between one type of cancer versus another?

A There are many different subtleties and variations, you know, in these. The tumors show varying degrees of differentiation, and different characteristics are evidenced in different tumors based upon their degree of differentiation.

Q So in terms of looking at a specimen that's gross pathology, could you distinguish between an embryonal cell carcinoma and a germ cell carcinoma?

A That's not possible.

Q So the defining characteristics would be perceived under microscopic analysis; is that correct?

A That's correct.

Q What about in terms of color, is that something looking microscopically at an embryonal cell versus --

A There are characteristic differences between seminomas and embryonal carcinomas based on their gross appearance. However, this line is blurred when you're talking about tumors that are showing expression of both tumors.

So while it's possible to say that a pure example of one case would have a certain characteristic appearance and a pure example of

another case would have another appearance, the distinction is not as clear-cut when there's more than one element involved in the tumor.

Q What would you do to make a determination in viewing a specimen microscopically to determine whether there is embryonal cell carcinoma present as opposed to seminoma?

A I would look for signs of epithelial differentiation.

Q Anything else?

A Well, that encompasses quite a number of different things, but that would be what I would be doing.

Q Aside from what you told me earlier, is there any more distinction you can break it down for me in terms of what you would look for more specifically under the epithelial differences?

A You would look €or the presence of glandular formations, Schiller-Duval bodies, you would look for lipid -- you would look for the little red droplets that contain alpha-fetoprotein. These are all things that are found in embryonal carcinoma that are not found in seminoma.

Q What about keratin?

A Keratin is evidence of epithelial differentiation.

Q What is keratin?

Keratin is a protein found in epithelial cells.

Q Is it the same as cytokeratin?

It's found in the cytoplasm, yes.

Q Is embryonal carcinoma an aggressive cancer?

MS. MILLER: Objection.

If it's untreated, it can be. This is an area actually outside of my field of expertise. I'm involved in the diagnosis of tumors and not in their treatment, and I would have to assume that in this day and age whether something is considered aggressive may or may not depend on how it's treated.

Q How about in terms of comparatively to a seminoma, is an embryonal carcinoma comparatively more aggressive or less aggressive than a seminoma?

MS. MILLER: Objection.

They are both malignant germ cell tumors which if left untreated might have grave consequences for the patient.

Q How do you determine if keratin is present in a cancer cell?

You use special stains.

Q Is that a stain that's done for immunoreactivity?

Yes.

Q Is that designated as AE1/AE3?

A Those are types of cytokeratin, yes.

Q You mentioned dealing with the diagnostic side, not so much the treating side. Is there a distinction that you're aware of between the treatment of the two cancers?

MS. MILLER: Objection. Are you asking him to comment on what he knows about treating cancer?

Q If you know. Within your realm of expertise, do you have knowledge of whether or not the treatment of these two types of cancers, the embryonal cell and the seminoma, are treated differently?

A Germ cell tumors that have nonseminomatous components are usually treated slightly more aggressively than pure seminomas.

(Plaintiffs' Exhibit 3 marked for identification)

Q Doctor, I'm going to show you what's been marked Exhibit 3. Just take a glance at that.

(Plaintiffs' Exhibit 4 marked for identification)

Q I'm handing you what's been marked Exhibit 4. First if you can identify number 3 for me.

A Number 3, it looks like a copy of the report from The Surgery Center on Thomas Ortman. SC95-1625.

Q Okay.
A Dated 5-12-95.
Q Is that your report?
MS. MILLER: Objection.
Q That you authored?
MS. MILLER: Objection.
A I was involved in it, yes.
Q Number 4 is a copy of number 3, but there's some handwriting on the bottom and on the left side of it. Is that your handwriting?
A No.
Q Any idea whose handwriting that is?
A No. It may be for coding purposes on the part of the secretaries. Are you talking about on the left-hand side of the page?
Q On the left-hand side it looks to be an initial, and on the bottom of the page that says T-78000 M-9061/3.
A I do not know what that is in reference to.
Q You had indicated, at least on number 3, that you were involved in this report. Tell me how it is that you were involved in this report.
A I looked at the slides, and I dictated the findings listed under "Microscopic Diagnosis."
Q You did not author the gross description?

A No, I did not see the gross specimen.
Q Do you know who saw the gross specimen?
A Dr. Tancinco.
Q Do you know how it is that you came to see the microscopic while Dr. Tancinco saw the gross?
A Because he was there the day before I was.
Q Just for someone who doesn't really know, how is it processed after the surgery in terms of getting the pathology to the pathology department?
A I'm not sure I understand the question.
Q Okay. I'm just wondering, the surgeon performs the surgery and then takes the specimen and sends it over to the pathology department for microscopic diagnosis, or is there a step in between? How does that work?
A Well, the specimen is obtained at surgery. It's usually placed in fixative, and then the paperwork identifying the specimen and the patient is submitted to the pathology department.
Q It's at that point in time when the gross description is done, when the pathology or the specimen is removed from the patient and placed into the fixative?
A No.
Q When is the gross pathology performed?

A After the specimen has been received by the laboratory.

Q Is there a reason why you would wait a day before doing the microscopic diagnosis after the gross pathology has been reviewed?

A Because the slides have to be prepared from the specimen. That usually takes a minimum of 24 hours.

Q Who makes the slides?

A Employees who specialize in histology.

Q You've had a chance to review the slides this morning before the deposition; is that correct?

A Uh-huh.

Q You have to say yes or no.

A Yes.

Q In reviewing those slides, did you hold the same opinion as to what you saw on May 12th, 1995, or May llth, 1995, that you d d when you saw them this morning?

A I'm able to identify areas of seminoma, and I have reviewed special stains that were done to demonstrate cytokeratin. I maintain that there is still seminoma within the tumor.

Q Did you see anything else within the tumor when you reviewed the slides beyond the seminoma?

MS. MILLER: Objection.

Q In terms of embryonal carcinoma?

MS. MILLER: Going back looking at the slides today?

Q Yes, as you looked at the slides today.

A They're both malignant germ cell tumors. There are varieties of seminoma, anaplastic seminoma that are similar in appearance to areas of embryonal carcinoma. I see primarily cells I interpret as seminoma. That's my conclusion.

Q Do you see any signs of embryonal carcinoma in reviewing the pathology?

MS. MILLER: Objection.

A I did not see what I considered clear-cut embryonal carcinoma in there.

Q Did you see anything in there that would give you reason to believe there may be embryonal carcinoma there?

MS. MILLER: Objection.

A Embryonal carcinomas often occur in combination with seminomas when there's a mixed germ cell tumor. This is always a consideration we have in the back of our minds when we're evaluating a germ cell tumor.

Q Did you see something in the slides when you looked at them today that indicated that there may be

embryonal carcinoma present?

MS. MILLER: - Objection.

A. I did not find an area that I was able to unequivocally diagnose as embryonal carcinoma in my review of the slides.

Q. Again my question was, did you see anything that could be embryonal carcinoma, not unequivocally, but could be embryonal carcinoma when you viewed it today?

MS. MILLER: Objection.

A. These are related tumors, and there could be an area of embryonal carcinoma in almost any germ cell tumor. I did not see any that I could specifically identify as embryonal carcinoma. I interpreted this initially as a seminoma.

Q. I understand initially. In terms of looking at it today, you have the same opinion that you did --

A. I did not find glandular areas. I didn't find -- I did not find areas showing alpha-fetoprotein. I didn't see Schiller-Duval bodies. I didn't see the characteristic findings that I associate with embryonal carcinoma.

There was a keratin stain, and the cells that I interpreted as seminoma did not stain with the keratin stain, and that's all I can say.

Q Doctor, did other cells stain with the keratin stain that were present?

A Yes. There were epithelial cells that are normal parts of the testes.

Q Any other cells besides the epithelial cells stain with the keratin?

A I did not identify other tumor cells that were staining.

Q As you looked at it today, were you able to identify any other tumor cells that were staining?

MS. MILLER: Objection.

A That's the only time I ever looked at it. Those stains were not --

Q They're not present on the slides?

A Those stains were not present at the time I evaluated the case.

Q Who did the staining?

A Who did the staining? I'm not sure where it was done.

Q Is staining something that's done microscopically? Is that how it's viewed? Is it part of a microscopic examination?

I The stains are something that can be requested as part of a microscopic examination.

Q Back in 1995, did you request staining for this as

part of your microscopic --

A That's a very general-- staining is a routine part of the procedure.

Q So you did request staining back in 1995?

A We're unable to interpret any of the slides without them being stained.

Q Did you have them stained for immunoreactivity for AE1 and AE3?

A No, I did not.

Q Why not?

A Because I did not feel there was convincing evidence on the hematoxylin and eosin stains that there was epithelial differentiation.

Q Were you able to determine if there was vascular invasion present?

A I did not see vascular invasion.

Q What is vascular invasion?

A Vascular invasion is a tumor that involves blood vessels.

Q What's the significance of that?

A The significance of it is that there's more chance for the tumor to spread if it's in blood vessels than if it's not.

Q So if you had to reissue your report that you authored for the microscopic diagnosis on 5-12 of

'95 today, would your report vary or change in any manner?

MS. MILLER: Objection. This is after his retrospective review of everything that's happened in this case or --

A Knowing that the tumor had metastasized, knowing that there is a question about the case, I might order some more special stains. I might order -- I might have ordered some other stains, but that's, you know.

Q Would you revise your diagnosis as a differential diagnosis to include embryonal carcinoma?

MS. MILLER: Objection.

A I might include that in a differential diagnosis.

Q At the time, can you tell me why that was not included as part of your differential diagnosis?

A Because I did not see epithelial differentiation.

(Plaintiffs' Exhibit 5 marked for identification)

Q Doctor, I'm going to show you what's been marked Exhibit 5. Have you had a chance to review -- can you identify it for me, please, first.

A This is a pathology report SC95-1625 dated 1-31-96 signed by Dr. Tancinco.

Q Those are the same slides that you reviewed in 1995,

correct?

A Some of them are, yes.

Q Is there a distinction as to how many slides were reviewed?

A There is not a distinction. There's no number of slides on this report.

Q Is there any designation as to how many slides you reviewed on your report dictated 5-12-95?

A No.

Q Incidentally, this morning you had a chance to review the slides. There were 12 slides present of 13. Do you know which slide was missing?

A No, I don't know what -- I can't tell what slide was missing. You have slides that I did not originally evaluate, that are not part of the original preparation, and I wouldn't know how many other slides you might have had made or prepared.

Q In looking at the slides, can you tell when they were prepared?

MS. MILLER: Do you want to bring those out?

MR. LANDSKRONER: Sure.

Q Which slides are you specifically interested in? If you can walk me through them and tell me which ones, if any, you can say when they were done, which

groupings. I want to be able to identify them if I can in terms of time f-rames.

Well, the slides labeled 1, 2, 4, 5 and 6 appear to be slides that are part of the original case. There is a slide designated number 5 that says recut number 1 that apparently was cut at some later date. That's why it's called a recut. And then there are six slides which are special stains that were done at a later date. One of those is dated 1-29-96.

Q Which, if you can recall, slides did you view at the original time of your diagnosis?

I looked at -- I did not look at the recuts, and I did not look at immunostains. I looked at the others.

Can you identify for me again that document? I don't know if you did, number 5.

Document number 5 is a revised report SC95-1625 signed by Dr. Tancinco that relates to Thomas Ortman.

Q Okay. In Dr. Tancinco's report he notes that there is intratubular germ cell neoplasia present.

Uh-huh.

Q Is that correct?

He describes intratubular germ cell neoplasia, yes.

Q Do you disagree with that finding?

MS. MILLER: Objection.

A I would have to specifically look for that again. You know, I can't tell you from -- I did not note it in my original report. I would have to review the slides again to see if that specific feature is part of this tumor.

Q Is that something that you can tell from the original slides?

A I'm not sure that I understand.

Q Would you need to look at the staining to determine that, or would you be able to tell from the original slides that you reviewed if that's present?

A That should show up in the original slides.

Q In your report dated 5-10 you indicate that intratubular germ cell neoplasia is not identified. Can you tell me whether or not in view of that you disagree with Dr. Tancinco's findings?

MS. MILLER: Objection.

A There's a discrepancy, there's a difference of opinion between those two reports.

Q Those are your findings --

One states that intratubular neoplasia is identified; the other one says intratubular neoplasia is not identified. Those are insight to noninvasive forms of tumor.

Q If Dr. Tancinco indicated that he found it was present, do you have any reason to disagree with him?

MS. MILLER: Objection.

A Well, do I have any reason to disagree with him. I did disagree with him at one time apparently. When I reviewed the slide originally, I did not recognize that. I wouldn't agree with him just because he happened to have put it in a report subsequently.

Q Okay. It's your opinion that there was no intratubular germ cell neoplasia on 5-12-95, correct?

MS. MILLER: Objection.

A When I reviewed the slides this morning, I did not specifically evaluate them for the presence of germ cell neoplasia, intratubular germ cell neoplasia, because this is not a feature that is of particular import in the diagnosis. And since I did not specifically look for that then, I can't tell you now whether it's there or not or whether I agree or disagree.

Q If it was present in 1995, should it have been in your report?

MS. MILLER: Objection.

A If I identified it, it should have been in my

report.

Q Should you have looked for it in 1995 as part of your --

A I'm sure that I did.

Q And you did not see it back at that time frame, back in 1995?

A I did not see it. Do you understand what the basis of these things are? These are indications for evaluation of staging. They are not anything that people would necessarily require to be in a report. A report, a satisfactory report, you know, a diagnostic report might not include those findings, but they are considered to be useful in terms of staging purposes.

Q You went as far as writing down on your report that intratubular germ cell neoplasia was not identified, so you looked for it?

A I was following templates that were at The Surgery Center for the evaluation of a testicular tumor, and I did not see intratubular germ cell growth at the time.

Q You did not see it on 5-12-95. Dr. Tancinco saw it on 1-31-96 based on these reports, correct?

A He describes it, yes.

Q You did not on 5-12-95 distinguish vascular

invasion. Dr. Tancinco distinguished that on 1-31-96, correct?

A He says that there's vascular invasion.

Q Why did you not indicate that there was vascular invasion at this t e?

A I didn't see it. The -- well, fine.

Q Dr Tancinco indicates that there are areas reminiscent of embryonal carcinoma or semin a, one or the other or both potentially And he further states in the end of his first paragraph of the microscopic description that, 'Intratubular neoplasi is also identified, probably intratubular embryonal carcinoma," correct?

A Uh-huh.

Q Why is it that you did not identify the intratubular embryonal carcinoma?

MS. MILLER: Objection

These tumors are related tumors. They are like looking at brothers. Okay? I did not identify the tumor as embryonal carcin a, so it is impossible that I would have recognized an intratubular portion of it as intratubular embryonal carcinoma.

Q So in essence, you missed the embryonal carcinoma?

MS. MILLER: Objection.

These tumors have -- they express themselves in a

variety of patterns, and these are all -- the tumor that I diagnosed was a malignant germ cell tumor, and it's Dr. Tancinco's opinion that in addition to the element that I found, there was another element.

Q. So you missed the embryonal carcinoma?

A. I will state this again. It is Dr. Tancinco's opinion that there is another element that I did not recognize.

(Plaintiffs' Exhibit 6 marked for identification)

Q. Doctor, I'm going to show you what's been marked Exhibit 6 and ask you if you can identify that for me.

A. Yes. This is a report from the Cleveland Clinic, S96-4032, in reference to the tumor on Thomas Ortman.

Q. That report is authored by Dr. Howard Levin, correct?

A. Yes.

Q. Dr. Levin finds in his final diagnosis that "Mixed malignant germ cell tumor, predominantly embryonal carcinoma with focal seminoma and malignant intratubular germ cell neoplasia" is present, correct?

A. That's stated on the report.

Q Dr. Levin found in viewing these slides the embryonal carcinoma, correct?

A He states that it was his opinion that there was embryonal carcinoma mixed with seminoma.

Q Do you disagree with Dr. Levin's statement that a large majority of the neoplasm is embryonal carcinoma?

MS. MILLER: Objection.

Q The first sentence of his comment.

A I interpreted this as being pure seminoma. Dr. Levin interprets this as being predominantly embryonal carcinoma.

Q So you disagree with what he says.

MS. MILLER: Objection. That's not what he said.

A I interpreted this as being a seminoma, and he interprets it as being a seminoma plus an embryonal carcinoma.

Q I'm asking you do you disagree with what his interpretation is.

A Well, we have already discussed that I don't find areas that are clearly and definitely embryonal carcinoma by my criteria, so it seems to me we're being redundant here. Dr. Levin finds that there is embryonal carcinoma as well as seminoma. That's his

opinion.

And just so we can get an answer, you disagree with his opinion?

MS. MILLER: Objection.

I am not able to document it by my criteria.

Q Doctor, I understand about your criteria.

I know, but, you know, I did not identify a germ cell -- I did not identify an embryonal component in this tumor when I diagnosed it in May of 1995.

Q I understand that.

Dr. Levin, looking at the same tissue, thinks that there is that component present. Why do we need to go on from here?

Q Because I just want you to answer the question whether you disagree or agree with what his opinion is.

MS. MILLER: Jack, are you looking for a yes or no?

A This is retrospective. I looked at this tumor in May of 1995, and I thought that it was a pure seminoma. Reviewing the same slides, Dr. Levin thinks that there is in addition to that embryonal carcinoma. He's entitled to his opinion and his evaluation.

Q In essence, you looked at the same materials, and

you have a different opinion than he does, correct?

I had a different opinion than he does -- than he did when I looked at it in May of '95.

Q And as of this morning when you looked at it, do you still have a different opinion?

I'm not able to clearly identify the areas described as being embryonal carcinoma.

(Plaintiffs' Exhibit 7 marked for identification)

THE WITNESS: Can we take a break for a few minutes?

MR. LANDSKRONER: Sure.

(Recess)

(Plaintiffs' Exhibit 8 marked for identification)

Q Doctor, I want to pick up where we left off and show you what's been marked Plaintiffs' Exhibit 7, ask if you can identify that for me.

This is a report from University Hospital that pertains to Thomas Ortman. That's S96-2828.

Q And again, that's, I think, underneath the final diagnosis line it says SC95-1625. Those are the slides from Mr. Ortman?

I'm sorry?

Q Right here.

This pertains to SC95-1625.

Doctor, you mentioned -you were familiar with Dr. Karim, pathologist at University Hospital?

Uh-huh.

And Dr. Karim finds in his final diagnosis in reviewing the slides of Mr. Ortman that there's mixed malignant giant cell tumor, predominantly embryonal carcinoma with focal seminoma.

I think that that is a typographical error. Mixed malignant giant cell tumor is a typographical error, and I'm sure Dr. Fadi will be glad to correct that for you if you check that with him. That is supposed to be germ cell tumor. This is probably dictated and not read.

Right. Predominantly embryonal carcinoma with focal seminoma. So Dr. Karim reviewed the pathology slides and found the embryonal carcinoma. Again, do you disagree or agree with Dr. Karim's findings that there was embryonal carcinoma present?

I cannot answer that yes or no. I did not find embryonal carcinoma when I initially evaluated the report, and I do not see areas that to me are clearly indicative of embryonal carcinoma. I am interpreting these areas as anaplastic seminoma.

With the exception of the typographical error,

potential typographical error, do you see any distinction between what Dr. Levin, Dr. Karim and Dr. Tancinco found in their evaluations of these slides?

They feel that in addition to seminoma there is also another component of germ cell -- another component of germ cell tumor, embryonal carcinoma, which I did not identify on the initial -- my initial evaluation.

Q Dr. Karim notes "suspicious for lymphatic invasion." What does that mean?

Well, you had commented on the possible presence of vascular invasion, and he's saying that there is an area that is suspicious for vascular invasion.

Q Again, something that you did not see in your evaluation of these slides?

I did not see vascular invasion.

Q Just for housekeeping purposes, if you will identify this for me. This is basically a photograph of that.

MS. MILLER: Objection.

Q It's marked Plaintiffs' Exhibit 8, if you can tell me what that is.

I have in my possession a Xerox copy of a number of slides, of 12 slides from The Surgery Center, some

of which appear to have been done as immunostains and some of which are H&E's.

Q Are those the same slides that you reviewed that we have in front of us?

A Yes.

Q Doctor, is there any information that you would like to have had prior to reviewing these slides in terms of medical records from Mr. Ortman to make your diagnosis? That you didn't have, I'm sorry.

A That I didn't have. Well, I think that in the evaluation of a testicular tumor it would be useful preoperatively to have alpha-fetoprotein and an HCG.

Q What's HCG?

A These are markers, serum markers which are elevated in nonseminomatous germ cell tumors,

Q And you did not have that information at the time you reviewed these slides?

A No, I did not have that information.

Q Again, you did not talk to any of the physicians that were involved in Mr. Ortman's care prior to evaluating these slides, did you?

A That's correct.

Q Were you aware that there was an ultrasound done on May 3rd, 1995 of Mr. Ortman?

A No.

Q Do you normally or on occasion have the opportunity to review ultrasound films before reviewing pathology?

A No.

Q Does your evaluation of pathology have anything to do with the staging of the cancer?

A There are elements of the report that are used in staging: The presence or absence of capsular invasion, the presence or absence of the tumor at the line of resection, things like this.

Q Anything in your report which is relative to the staging of this tumor?

A Yes.

Q Will you point that out for me?

A Everything below the diagnosis of seminoma is related to staging.

Q Do you put a designation as to what stage the tumor is?

A No.

Q Is that something that's left to the oncologist or the surgeon?

A That's correct.

Q Doctor, does the standard of care for pathologists require you to be able to look at a pathology slide and determine whether a cancer is embryonal cell or

seminoma?

A. By -- I don't know how you're defining standard of care. I mean it's not a document.

Q. By standard of care, I'm referring to acting as a reasonable physician in your area of specialty.

A. Yes, it would -- could you ask me the question again. I'm not sure I understand.

Q. Sure. The question is, does the standard of care in your area of specialty require that you be able to look at a pathology slide and determine whether a cancer present is embryonal carcinoma or seminoma?

MS. MILLER: Can you answer that question?

A. I don't know that it's yes or no. There are cases that are clear-cut and they're different, and then there are cases where the cells are very similar and no one can identify which is exactly which. The easy cases are easy, and the hard cases are hard.

The hard cases no one can definitely tell which is which, and the easy cases anyone can tell which is which. I mean it's not an all or none phenomena.

Q. In medical school you were taught and through the course of your practice you were taught the distinguishing characteristics and traits between

the two, though, correct?

In my residency training and through experience I have learned to differentiate the differences, and they are some of the things we've discussed.

In this case, most of the discriminating features between embryonal carcinoma and anaplastic seminoma are not present. They're not described. There's no gland formation, there's no evidence of alpha-fetoprotein, there's no evidence of the characteristic tubular structures that are associated with embryonal carcinoma.

This tumor has a few clumps of cells growing as sheets and a heavy lymphoid infiltrate, which are characteristics of seminoma.

Q Doctor, do you have any criticism of the conduct or the action of Mr. Ortman in this case?

MS. MILLER: Objection.

A I have no knowledge of his conduct.

Q Do you have any criticism of any of the other care providers in this case?

A No.

Q A couple questions that I have to ask you, and I apologize in advance, but have you ever been convicted of a state or federal offense?

A No.

Q Criminal offense. Have you ever been treated for any alcohol or substance abuse?

No.

Q Have you ever served on any hospital or review committees in quality review beyond what we've previously discussed?

I'm not sure I understand that. In all the committees and things that you're involved in, there are elements of quality control and quality assurance involved in them, and I haven't specifically been on a committee that was called the quality control committee, if that's what you're asking.

Q Okay. Peer review or anything like that?

I have not served on a peer review committee.

Q The organizations that you belong to that are involved are listed on your curriculum vitae, correct?

Yes.

Q Doctor, would you agree that the prognosis of a patient depends on the cancer cell type in the time frame of diagnosis for the treatment of the patient?

MS. MILLER: Objection.

MR. POLITO: Same objection.

Yes.

Q. Do you agree that the longer the delay in treatment, the greater the risk to the patient?

MS. MILLER: Objection. You're asking him as a pathologist about diagnostics or prognostics; is that correct?

MR. LANDSKRONER: I'm asking him about general knowledge that he may have concerning cancer.

MS. MILLER: Objection.

MR. POLITO: Objection.

A. I can't answer yes or no because --

MS. MILLER: You answered. You can't answer.

Q. You said you couldn't answer yes or no. Anything else to add to that?

A. I can't answer beyond yes or no.

Q. Can you tell me what the risks of embryonal cell carcinoma going untreated are?

MS. MILLER: Objection.

A. What the risks are? The risk is metastatic cancer and death.

Q. Would you agree that the clarity of tumor identification is vital to evaluating correct treatment for each type of tumor?

MS. MILLER: Objection.

No.

Why not?

Because many tumors are treated with the same chemotherapy and the same therapy, and frequently the histologic differentiation between tumors is of interest primarily to the pathologists and is not of clinical significance to the oncologists.

Many lymphomas are treated the same way. Many metastatic diseases are treated the same way. So as a general statement, I would disagree.

Q How about specifically dealing with the identification of a seminoma versus an embryonal carcinoma?

MS. MILLER: Objection.

MR. POLITO: Objection.

That's really beyond my expertise.

Doctor, had you seen the gross pathology at the time it was done, would it have changed anything in your opinion in terms of the microscopic?

Probably not.

Q Do you use a written protocol checklist in terms of distinguishing between the type of tumor in testicular cancer?

Would you repeat the question.

Q I'll rephrase the question. It was a bad question.

When you were evaluating these slides, did you use a written protocol check-list in terms of what you were looking for?

There was a template related to staging that was used.

Q What is that? Is it a document? Can you explain what the template is?

A It's a list of things to look for: tumor size, the presence or absence of intratubular germ cell neoplasia, whether the capsule is involved, whether the epididymis is involved and whether there's tumor at the receptive margin.

Is that a template that's maintained by Southwest Hospital or The Surgery Center or --

It's something that was developed within the pathology department.

At Southwest General Hospital?

Yes.

MR. LANDSKRONER: I would make a request for the template.

MS. MILLER: Jack, he's reading right off the -- that's the template from the report.

MR. LANDSKRONER: But there's a document that actually exists --

MS. MILLER: It's not a document. Is it a document?

There's a form and it says tumor size, then it says intratubular germ cell neoplasia yes or no, involvement of tunica albuginea yes or no. It's just basically what we have here.

MR. LANDSKRONER: I'd like to see the form if you can get the form for me.

MS. MILLER: If Dr. Alberhasky doesn't have control of that, I can't provide that to you.

MR. LANDSKRONER: I now request it otherwise if you have it.

MS. MILLER: I don't have anything like that.

MR. LANDSKRONER: That's all I have.

MR. POLITO: I have no questions.

MS. MILLER: Doctor, if this is typed up, you have a right to read it for any errors in transcription. While she's competent, this doesn't follow certain medical terminology, so I suggest you read it and tell her you do not waive your signature.

THE WITNESS: Okay.

(Deposition concluded at 3:55 p.m.)

I have read the foregoing transcript from page 1 through 63 and note the fallowing corrections:

PAGE	LINE	REQUESTED CHANGE

_____

Robert Alberhasky, M.D.

Subscribed and sworn to before me this _____ day of _____, 1997.

_____

Notary Public

My commission expires _____

State of Ohio,)
) SS: CERTIFICATE
County of Cuyahoga,)

I, Phyllis L. Englehart, RMR and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, Robert Alberhasky, M.D., was by me first duly sworn to testify the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to computerized stenotypy in the presence of said witness, afterward transcribed, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and completed without adjournment.

I do further certify that I am not a relative, counsel, or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 26th day of May, 1997.

Phyllis L. Englehart, RMR and Notary Public
in and for the State of Ohio
My commission expires June 23, 2001.

CURRICULUM VITAE

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PERSONAL HISTORY

Birthdate:	March 27,1950
Birthplace:	Louisville, Kentucky
Marital Status:	**Married**
Social Security Number:	**400-64-6726**

EDUCATION

UNDERGRADUATE **1968 - 1972**	**Indiana** University **Bloomington,** Indiana Chemistry B.S.
MEDICAL SCHOOL **1972-1976**	University of Louisville Louisville, Kentucky School of Medicine
INTERNSHIP **1976-1977**	University of Louisville Louisville, Kentucky Department of Pathology
RESIDENCY **1977-1980**	University of Louisville Louisville, Kentucky Department of Pathology
CHIEF RESIDENT **1978-1979**	University of Louisville Louisville, Kentucky Department of Pathology

FELLOWSHIPS

ASSISTANT INSTRUCTOR **1978-1979**	University of Louisville Louisville, Kentucky School of Medicine
CLINICAL FELLOWSHIP **1980-1981**	University of Louisville Louisville, Kentucky J. Graham Brown Cancer Center

LICENSURE

Kentucky Medical Licensure Board
No. 19449
1977

Ohio Medical Licensure Board
No. **046298**
1981

CERTIFICATION

1980 — Board Certified Anatomic Pathology/Clinical Pathology
American Board of Pathology

1994 — College of American Pathology (CAP)
Laboratory Inspector

MEMBERSHIP

College of American Pathologists

Ohio Society of Pathologists

Cleveland Society of Pathologists

EMPLOYMENT

July 1978 - July 1980 — Clinical Diagnostic Laboratory-National Health Laboratories

September **1980** - June **1981** — Consultant **Park** DuValle Community Health Center

July **1981** - February **1995** — Pathology Associates, Inc.
Euclid General Hospital
Euclid, Ohio
Department of Pathology
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March **1995** - December **1995** — Bayless-Pathmark, Inc.
Southwest General Hospital
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December **1995** to Present — Bayless-Pathmark, Inc.
Smith-Kline Beecham Laboratories
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PUBLICATIONS

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Euclid Medical Office Plaza
26250 Euclid Avenue
Euclid, Ohio
(216) 289-1415

Maurice Coffee, MD.
Pulmonary Medicine
University Hospital/Case Western Reserve
University Mednet/Euclid Clinic
18599 Lakeshore Blvd
Euclid, Ohio
(216) 383-8500

Thomas Slawinski, M.D.
General Surgery
Euclid Medical Office Plaza
26300 Euclid Avenue
Euclid, Ohio
(216) 2614990

PATHOLOGY CONSULTATION REQUEST AND QUALITY CONTROL FORM

DATE 5-11-95

CASE NO. S95-1625

PATIENT NAME ORTMAN, THOMAS

AGE: 36 DOB: 10-24-58 SEX: M

THE SURGERY CENTER

19250 EAST BAGLEY ROAD • MIDDLEBURG HTS. OHIO 44130
216-826-3240

SPECIMEN (R) TESTICLE

HISTORY

PATHOLOGIST REQUESTING CONSULTATION RA

DATE	CONSULTING PATHOLOGIST	DIAGNOSIS
5-11-95	RCR	seminoma - tunica has pickup, not invasive
5-11-95	KG	agree

PLAINTIFF'S EXHIBIT 2

PENGAD-Bayonne, N. J.

THE SURGERY CENTER
19250 EAST BAGLEY ROAD • MIDDLEBURG HTS., OHIO 44130 • 216-826-3240

PATHOLOGY LABORATORY

NAME:	ORTMAN, THOMAS	PATH No.: SC95-1625
DATE RECEIVED IN LAB:	5-10-95 at 10:49 a.m.	AGE: 35 SEX: M
PHYSICIAN:	Dr. Basa	DATE OF BIRTH: 10-24-58
SPECIMEN:	Right testicle	
DATE OF PROCEDURE:	5-10-95	
PRE-OPERATIVE DIAGNOSIS:	Tumor right testicle	
POST-OPERATIVE DIAGNOSIS:	Pending	

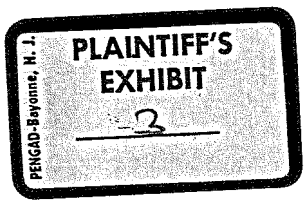
GROSS DESCRIPTION: Received in Prefer fixative is a testicle, designated the right, which weighs 26.7 gams, and comes with attached epididymis and contents of spermatic cord. The testicle measures 4.5 X 2.8 X 2.5 cm. The tunica albuginea is smooth, glistening, and gray-tan showing two brown sutures sewn around a portion of the tunica and enclosing a portion of light brown apparent testicular tissue measuring up to 1.0 X 0.3 X 0.2 an. Otherwise, no abnormalities are noted. Cut section of the testicle reveals a slightly bulging and firm, irregular gray-white tumor measuring up to 1.8 X 1.6 an. in dimension. On cut section, the tumor shows areas of hemorrhage. The tumor does not extend to the tunica, nor does it extend into the epididymis. Other cut sections of the testicle away from then tumor are unremarkable. The edididymis and contents of the spermatic cord are unremarkable.
Representative sections are submitted in six cassettes. Designations #1 is contents of spermatic cord line of resection, #2 is section of tumor and adjacent testicle, #3 through #5 are sections of tumor with tunical margin and #6 is adjacent abnormal appearing testicle and epididymis.

BFT/ef

R(DIA(SIS

RIGHT TESTES:
SEMINOMA
TUMOR SIZE: 1.8 CM. IN DIAMETER
INTRATUBULAR GERM CELL NEOPLASIA: NOT IDENTIFIED
TUNICA ALBUGINEA: NOT INVOLVED
EPIDIDYMIS, NOT INVOLVED
SPERMATIC CORD AND MARGINS: NOT INVOLVED

RA/ef
5-12-95
88309



R. ALBERHASKY, M.D.

THE SURGERY CENTER
19250 EAST BAGLEY ROAD • MIDDLEBURG HTS., OHIO 44130 • 216-826-3240

PATHOLOGY LABORATORY

NAME:	ORTMAN, THOMAS	PATH No.:	SC95-1625
DATE RECEIVED IN LAB:	5-43-95 at 10:49 a.m.	AGE: 36 SEX: M	
PHYSICIAN:	Dr. Basa	DATE OF BIRTH:	10-24-58
SPECIMEN:	Right testicle		
DATE OF PROCEDURE:	5-10-95		
PRE-OPERATIVE DIAGNOSIS:	Tumor right testicle		
POST-OPERATIVE DIAGNOSIS:	pending		

GROSS DESCRIPTION: Received in Prefer fixative is a testicle, designated the right, which weighs 26.7 grams, and comes with attached epididymis and contents of spermatic cord. The testicle measures 4.5 X 2.8 X 2.5 an. The tunica albuginea is smooth, glistening, and gray-tan showing two brown sutures sewn around a portion of the tunica and enclosing a portion of Light brown apparent testicular tissue measuring up to 1.0 X 0.3 X 0.2 an. Otherwise, no abnormalities are noted. Cut section of the testicle reveals a slightly bulging and firm, irregular gray-white tumor measuring up to 1.8 X 1.6 cm. in dimension. On cut section, the tumor shows areas of hemorrhage. The tumor does not extend to the tunica, nor does it extend into the epididymis. Other cut sections of the testicle away from then tumor are unremarkable. The edididymis and contents of the spermatic cord are unremarkable.
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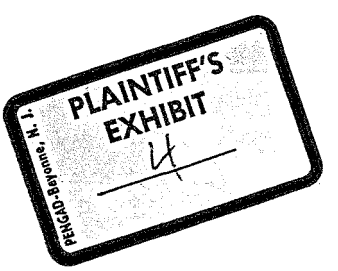
BFT/ef

MICROSCOPIC DIAGNOSIS:

RIGHT TESTES:
SEMINOMA
TUMOR SIZE: 1.8 CM. IN DIAMETER
INTRATUBULAR GERM CELL NEOPLASIA: NOT IDENTIFIED
TUNICA ALBUGINEA: NOT INVOLVED
EPIDIDYMIS, NOT INVOLVED
SPERMATIC CORD AND MARGINS: NOT INVOLVED



RA/ef
5-12-95
88309

T-78000
M. 9061/3

for
R. ALBERHASKY, M.D.

REVISED REPORT

THE SURGERY CENTER
19250 EAST BAGLEY ROAD • MIDDLEBURG HTS., OHIO 44130 • 216-826-3240

PATHOLOGY LABORATORY

NAME: ORTMAN, THOMAS
PATH No.: SC95-1625

DATE RECEIVED IN LAB: 5-10-95 at 10:49 a.m.
AGE: 36 SEX: M

PHYSICIAN: Dr. Basa
DATE OF BIRTH: 10-24-58

SPECIMEN: Right testicle

DATE OF PROCEDURE: 5-10-95

PRE-OPERATIVE DIAGNOSIS: Tumor right testicle

POST-OPERATIVE DIAGNOSIS: pending

REVISED DIAGNOSIS:

RIGHT TESTIS:
MIXED SEMINOMA AND NON-SEMINOMATOUS GERM CELL TUMOR (EMBRYONAL CARCINOMA)

TUMOR SIZE: 1.8 CM.
INTRATUBULAR GERM CELL NEOPLASIA: PRESENT
VASCULAR INVASION: PRESENT
TUNICA ALBUGINEA: NEGATIVE FOR TUMOR
EPIDIDYMIS: NEGATIVE FOR TUMOR
SPERMATIC CORD AND MARGINS: NEGATIVE FOR TUMOR

MICROSCOPIC DESCRIPTION: This is a difficult lesion *to* classify; however, it appears that there are two distinct components *to this* tumor. There appears to be a minor component of seminoma admixed with larger areas of anaplastic tumor showing solid nests of tumor cells containing central necrosis and numerous mitoses, some of which are atypical. The nuclei are highly pleomorphic with prominent nucleoli. These areas are reminiscent of embryonal carcinoma or seminoma with carcinomatous transformation. Intratubular neoplasia is also identified, probably intratubular embryonal carcinoma.

Immunoperoxidase stains show focal immunoreactivity for AE1/AE3 within the highly anaplastic areas. This positivity is typically seen in non-seminomatous germ cell tumors *such* as embryonal carcinoma, whereas *seminomas* are usually negative.

COMMENT: This case is being forwarded to H. S. Levin, M.D. for consultation with *a* supplementary report to follow.

BFT/ef
1-31-96

B. F. TANCINCO, M.D.

DR. BASA

THE CLEVELAND CLINIC FOUNDATIO

DIVISION OF PATHOLOGY AND LABORATORY MEDI[illegible] E
DEPARTMENT OF ANATOMIC PATHOLOGY
9500 EUCLID AVENUE CLEVELAND, OHIO 44195
SURGICAL PATHOLOGY REPORT

Nar ORTMAN, THOMAS — SPECIMEN #: S96-4032 *

Patien: ID #: NONE — Financial #: 287369
Managed Care ID #: — Date of Report: 02/05/96
DOB: 10/24/58 (Age: 37) M — Date of Procedure: 05/10/95
Date of Receipt: 02/02/96
Location:

Submitted by: The Surgery Center
Department ofo Pathology
19250 E. Bagley Road
Middleburg Hts, Ohio 44130
FAX: 826-3250

Requested by: DR. TANCINCO

SPECIMEN(S) SUBMITTED:
13 SLIDES & 3 BLOCKS (SC95-1625)

****

FINAL DIAGNOSIS

.TESTIS (EXCISION, RIGHT, SC95-1625)
- MIXED MALIGNANT GERM CELL TUMOR, PREDOMINANTLY EMBRYONAL CARCINOMA WITH FOCAL, SEMINOMA AND MALIGNANT INTRATUBULAR GERM CELL NEOPLASIA.

Comment: The neoplasm measures 1.8 cm. in maximum dimension. A large majority of the neoplasm is embryonal carcinoma with a focus of seminoma in one slide. There is no evidence of tunica albuginea invasion. There is, however, probable invasion of endothelial-lined spaces, probably representing lymphatics. The tumor invades the rete testis and microfocally extends into connective tissue adjacent to the rete testis. No tumor is identified in the spermatic cord or the epididymis.' Immunoperoxidase stain for keratin (AE1/3) demonstrates positivity in some cells of the embryonal carcinoma. Seminoma cells stain negatively for keratin.

HSL/kmr/2-5-96

Howard S. Levin M.D.

****

PLAINTIFF'S EXHIBIT 6
PENGAD-Bayonne, N. J.

--End of Report--

PHYSICIAN COPY - DO NOT CHART

UNIVERSITY HOSPITALS OF CLEVELAND

DEPARTMENT OF PATHOLOGY

11100 Euclid Avenue - Cleveland, OH 44106
Phone (216) 844-1806 FAX (216) 844-1810

Patient Name: ORTMAN, THOMAS
Patient #: 01840928
SS#: 278-60-5506
DOB/Age/Sex: 10/24/58 (Age: 37) M
Race: CAUCASIAN
Location:
Date of Service:
Visit #
Visit Type:

CONSULTATION REPORT

Date of Procedure:
Date Received: 02/09/96
Date Reported: 02/12/96

SPECIMEN #: S96-2828*
Ordering Physician: CINDY R. CONNELLY, MD
Attending Physician(s):

FINAL DIAGNOSIS:

SC95-1625 (5/10/95)

RIGHT TESTIS, EXCISION: MIXED MALIGNANT GIANT CELL TUMOR, PREDOMINANTLY EMBRYONAL CARCINOMA WITH FOCAL SEMINOMA, SEE COMMENT.

MALIGNANT INTRATUBULAR GERM CELL NEOPLASIA.

Comment: There is no evidence of tunica albuginea? There are however foci suspicious for lymphatic invasion. The tumor invades the rete testis and microscopically extends into connective tissue adjacent to the rete testis. No tumor is identified in spermatic cord or epididymis. Immunoperoxidase stain for keratin (AE 1/3) shows focal positivity in the embryonal carcinoma. There is no histopathologic evidence of choriocarcinoma or yolk sac tumor. The tumor size is reported to be 1.8 cm.

FAK/em

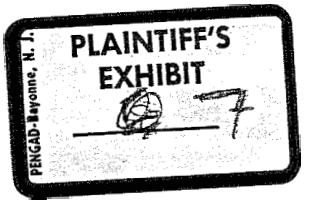
** Report Electronically Signed Out **
Fadi Abdul-Karim M.D.

SPECIMEN(SI SUBMITTED:

SC95-1625 (5/10/95)

CLINICAL DIAGNOSIS AND HISTORY:

{ None Given }



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Continued on Next Page

UNIVERSITY HOSPITALS OF CLEVELAND
DEPARTMENT OF PATHOLOGY
11100 Euclid Avenue - Cleveland, OH 44106 Phone (216) 844-1806 FAX (216) 844-1810

GROSS DESCRIPTION:

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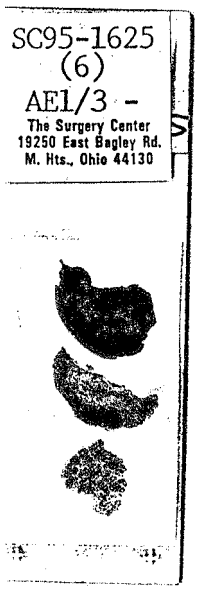

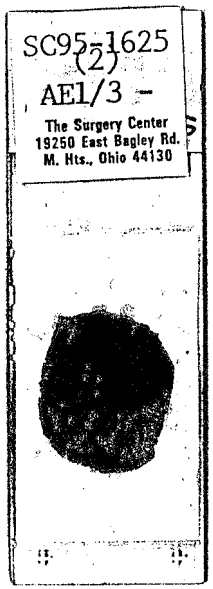

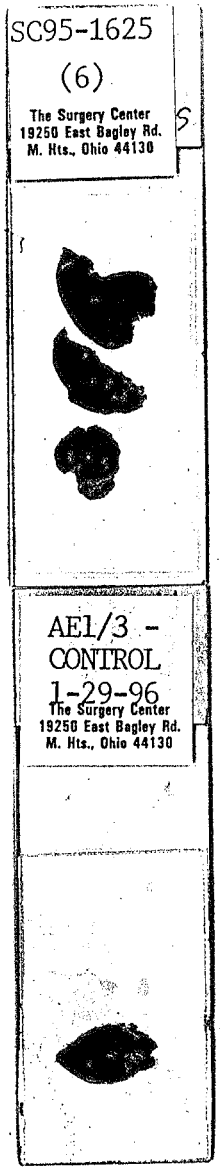

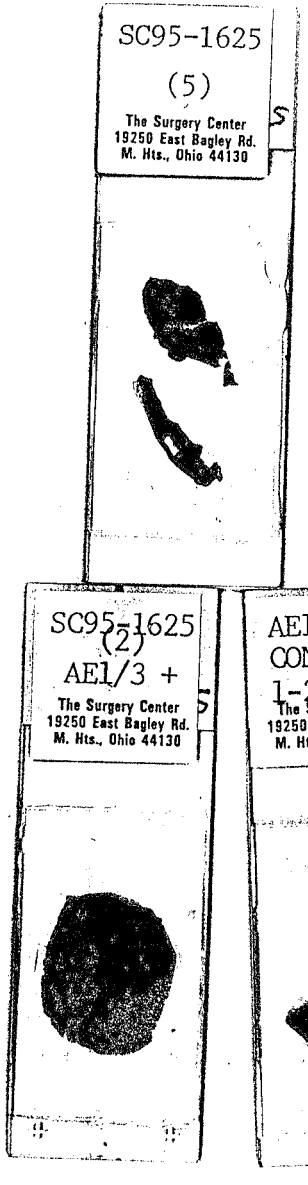

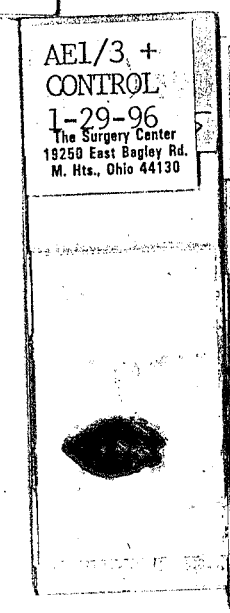

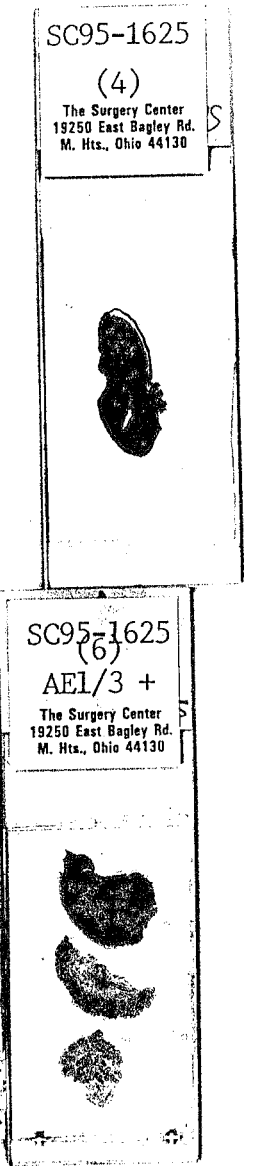

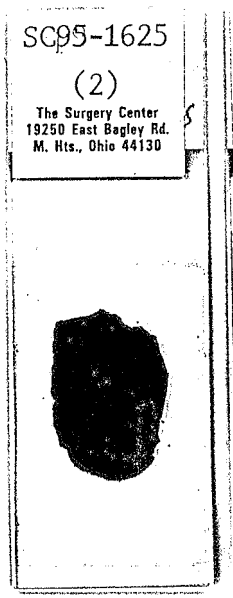

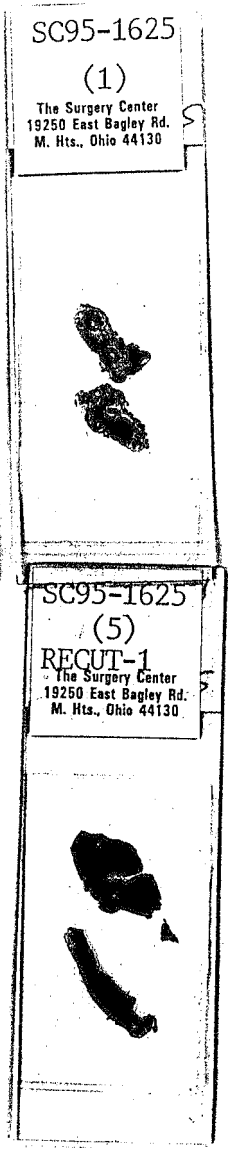

PENGAD-Bayonne, N.J.

PLAINTIFF'S EXHIBIT 8