IN THE COURT OF COMMON PLEAS OF CUYAHOGA COUNTY, OHIO

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Angela DiCicco,
Administratrix of the
Estate of Carl Pietrangelo, :

Plaintiff, :

vs. : Case No. 348542
Judge P. Cleary

Meridia Hillcrest Hospital, :
et al.,

Defendants.

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DEPOSITION

of Robert R. Bahnson, M.D., a witness called by the Plaintiff under the applicable Rules of Civil Procedure, taken before me, Maria DiPaolo Jones, a Notary Public in and for the State of Ohio, by agreement of counsel and without notice or legal formality, at OSU Clinic, 456 West Tenth Avenue, Columbus, Ohio, on Monday, October 4, 1999, at 3:10 p.m.

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APPEARANCES:

Spangenberg, Shibley & Liber
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On behalf of the Plaintiff.

Weston, Hurd, Fallon, Paisley & Howley, L.L.P.
By Mr. Harry Sigmier
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On behalf of Defendant Dr. Luria.

Weston, Hurd, Fallon, Paisley & Howley, L.L.P.
By Mr. Dennis R. Fogarty
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On behalf of Defendant Doctors Hill & Thomas Co., and Dr. Charms.

Reminger & Reminger
By Mr. Brant E. Poling
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On behalf of Defendant Meridi Hillcrest Hospital.

Davis & Young
By Mr. Kevin Norchi
1700 Midland Building
101 Prospect Avenue West
Cleveland, Ohio 44115-1027

On behalf of Defendant Dr. Siminovitch.

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Monday Afternoon Session,
October 4, 1999.

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STIPULATIONS

It is stipulated by and among counsel for the respective parties that the deposition of Robert R. Bahnson, M.D., a witness called by the Plaintiff, may be taken at this time by the Notary by agreement of counsel without notice or other legal formality; that said deposition may be reduced to writing in stenotypy by the Notary, whose notes thereafter may be transcribed out of the presence of the witness; and that proof of the official character and qualification of the Notary is waived.

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ROBERT R. BAHNSON, M.D.

being by me first duly sworn, as hereinafter certified, deposes and says as follows:

EXAMINATION

By Mr. Lansdowne:

Q. Doctor, would you state your full name for the record, please?

A. Robert Roy Bahnson.

Q. Dr. Bahnson, we met just for a second before the deposition here. My name's Dennis Lansdowne. I represent the family of Mr. Carl Pietrangelo in this case that is pending in Cuyahoga County, and you have been identify as an expert on behalf of Dr. Siminovitch. I take it you are going to be an expert on behalf of Dr. Siminovitch in this case.

A. I am.

Q. All right. I'm here to ask you some questions to find out what opinions you hold and the bases for those opinions that you intend to render in this case. Do you understand that's the purpose of our being here today?

A. I do.

Q. All right. You've given depositions before?

A. I have.

Q. On how many occasions?

A. I don't recall.
Q. How many in the last year?
A. Don't recall.
Q. Is it more than ten within the last year?
A. I don't recall.
Q. Is it more than five?
A. I don't recall.
Q. Is it less than 20?
A. I don't recall.
Q. Okay. You have no idea how many depositions you've given in the last year; is that correct?
A. I don't recall.
Q. Okay. How would we find that out?
A. I don't know.
Q. Do you have any record of the depositions that you've given in the past year?
A. I do not.
Q. Could it be as many as a hundred?
A. It could not,
Q. Okay. Could it be as many as 50?
A. I doubt it.
Q. Okay. Is it more likely around 25?
A. I don't recall.
Q. Okay. Somewhere between 25 and 50?
A. I don't recall.

Q. Okay. In what circumstances were you involved in depositions in the last year?

A. Medical malpractice cases.

Q. All of them? All the depositions that you've given in the past year were medical malpractice cases?

A. Yes.

Q. And have you testified in a courtroom in the last year?

A. Yes.

Q. Again, medical malpractice case?

A. Yes.

Q. And I almost hate to ask this, but how many times have you testified in a courtroom in the last year?

A. Don't recall.

Q. How about where? Do you remember where you testified?

A. I remember one testimony.

Q. Where was that?

A. That was in Kittanning, Pennsylvania.

Q. All right. And how long ago was that?

A. I don't specifically recall the dates.

Q. All right. You testified in a courtroom in Ohio before?

A. To the best of my recollection, no.

Q. How is it that you get involved as an expert in medical malpractice cases?

A. I'm usually contacted by an attorney or someone representing an attorney.

Q. Do you know how attorneys get your name for that purpose?

A. I don't know.

Q. Do you belong to any service that provides expert witnesses to people?

A. I do not.

Q. Have you ever?

A. I have never.

Q. All right. Have you worked with Mr. Norchi before in any medical malpractice case?

A. To the best of my recollection, no.

Q. How about the firm of Davis & Young?

A. To the best of my recollection, no.

Q. Have you ever worked with any firm in the city of Cleveland before in a medical negligence case?

A. To the best of my recollection, no.

Q. Okay. Do you know how it is that Mr. Norchi came to contact you in this case?

A. I do not know.

Q. All right. Do you know Dr. Siminovitch?

A. I do not.

were you retained on behalf of the defense?

A. To the best of my recollection, for the past year, all of them.

Q. Why is that?

A. I have no idea.

Q. Have you ever testified in deposition on behalf of a patient in a medical negligence case?

A. I have.

Q. On how many occasions?

A. One that I recall.

Q. One in your entire career?

A. Yes.

Q. So are you able to give any percentage of how many cases you testified on behalf of the plaintiff as opposed to the defendants?

A. The majority would be on the defense side.

Q. Ninety-nine percent, would you say?

A. I don't recall.

Q. It might be 99 percent, but you're not sure.

A. It might be.

Q. Okay. What do you understand *is* meant by the term "standard of care"?

A. Commonly accepted practice.

Q. I need to do some housekeeping things in terms of your charges and things like that. What are your

charges for involvement in a medical negligence matter?

A. As an expert?

Q. I suppose you don't charge to be a party, but what are your charges as an expert?

A. As an expert what I charge is $250 an hour to review materials, and that's on time outside of what I would call normal working hours.

Q. Right.

A. And for a deposition I charge a minimum of $1,500, and if the deposition takes longer than the amount of time that I would normally assign to a deposition, it could be more.

Q. Okay.

A. And it's really based on a daily charge of $3,500, which is what I charge for a testimony if I'm involved in a trial. And that's on a day, basis so, essentially, an eight-hour day.

Q. So just so I know, I am being charged $1,500 for this deposition, and how long do I have before it kicks into another charge?

A. It would have to exceed eight hours.

Q. Okay. I think I'm safe.

MR. NORCHI: I hope you're safe.

MR. FOGARTY: I hope so.

MR. POLING: You better be.

Q. Actually, these other gentlemen --

A. Actually, that' -- I don't think -- gave you another answer, and I apologize.

Q. Go ahead.

A. I used to decipher in my head, and I can't, so $3,500 divided by eight hours.

Q. I see.

A. But I think you're safe.

Q. All right.

A. I do have to excuse myself at 5:00, I'm sorry, so that is a --

Q. That's it?

A. Yes, sir.

Q. 5:00?

A. Yes, sir.

Q. Okay. Well, for the record, I may not be done at 5:00, but if you have to go, you have to go, and we'll have to deal with it with the judge.

A. Okay.

Q. Because, obviously, we can't hold you.

A. Sure.

Q. Let me remind -- just as you did now correcting yourself, feel free at any time to correct an answer that you've given earlier, add to it or amend it, okay?

A. Yes.

Q. And if you don't understand my question or I use a medical term incorrectly or in a fashion that you don't think it should be used, please advise me of that, all right?

A. I will.

Q. All right. Are you an employee of Ohio State? Is that how that works?

A. I am not.

Q. Who are you employed by?

A. The Department *of* Surgery Corporation.

Q. The Department *of* Surgery Corporation, What is that?

A. It's a corporation engaged in the practice of medicine in the State of Ohio.

Q. Is it just for the urology surgeons, or does it include other surgeons?

A. Includes other surgeons in the Department of Surgery.

Q. Okay. And do you have any specific title within that corporation?

A. I do. I am a vice president.

Q. All right. And what about your title in the Department, do you have a specific title within that?

A. *Yes.* I am the Louis Levy Professor and I -- in the Department *of* Surgery.

Q. What is that, the Louis Levy Professor of Surgery?

A. Louis Levy was a Columbus denizen who made a fortune in auto parts and was a patient of Dr. Chester Winter, a former chairman of the Division of Urology, and in his gratitude for the care that he received, he contributed a sum of money to the University which is now in a development account. That money is of sufficient size that it endows a professorship in Mr. Levy's name, and I currently occupy that professorship.

Q. I see. Have you, since you mentioned another possible involvement in a case, have you ever been a party in a medical negligence case?

A. By a "party," a defendant?

Q. That would be one party. Have you ever been a defendant in a lawsuit, medical negligence lawsuit?

A. Yes.

Q. On how many occasions?

A. I have been named in three lawsuits.

Q. Are any of those still pending?

A. Yes, two of them.

Q. What do those involve?

A. Allegations of malpractice.

Q. With regard to what? What specific issues? Do

you know?

A. Yes. In one case a patient that I operated on for prostate cancer is alleging that I negligently performed his surgery and that he developed impotence and incontinence after surgery. I understand the complaint's being amended because the judge has said that that's insufficient grounds for an allegation of negligence because those are both common complications of that procedure, and as of yet the Plaintiff's attorney has not filed an amended complaint.

MR. NORCHI: Doctor, if you could, just explain what the issue is. If these are pending cases in which you should be represented by counsel, I would suggest that you don't give too much detail. You can explain to him what the issues are in the complaint, I assume that's a matter of public record, but anything else is improper, and I'm advising you of that.

I mean, if you choose to answer, I can't stop you, but I would suggest you need to be represented by your own counsel in those cases. But go ahead, the second lawsuit?

A. Second is an allegation of negligence, and on advice of counsel, I will have nothing more to say.

Q. Okay. And where are those pending, here in Co1umbus?

A. On the advice of counsel, I have nothing more to say.

MR. NORCHI: You can tell him where they're pending.

Q. That would be public record, Doctor.

A. The one is in Pittsburgh, and one is in Columbus.

Q. And you said there is one other one that's no longer pending; is that right?

A. It was dismissed for -- it was dismissed.

Q. What percent of your professional time do you spend as an expert in medical negligence cases?

A. I would guess that it's somewhere between zero -- well, it can't be zero. It's between 1 and 2 percent.

Q. Have you ever testified that a person would have survived if their renal cancer had been diagnosed earlier?

A. To the best of my recollection, I have not made that testimony.

Q. Have you ever seen such a situation where you thought that if the person had been diagnosed earlier, they would have survived?

A. My father; yes.

Q. I don't want to get into a personal situation,

Doctor, but is that a situation in which you felt that somebody did not appropriately diagnose a renal cell cancer?

A. Oh, he didn't have a renal cell cancer. I'm sorry, I didn't know you restricted it to a renal cell cancer.

Q. Was it a kidney cancer?

A. No.

Q. Some other type of cancer that you thought should have been diagnosed earlier?

A. No. It was another condition that had it been diagnosed earlier, he probably would have lived.

Q. Okay. And you felt that the physicians involved should have diagnosed it earlier?

A. No,

Q. Have you ever seen a situation in which -- let me be more specific, then. You thought that physicians should have diagnosed a type of cancer earlier than it was diagnosed?

A. Yes.

Q. And did those involve patients that have come to you?

A. Yes.

Q. And looking back at their charts you thought that they probably should have been diagnosed earlier by

their physician?

A. Yes.

Q. Did you advise the patients that they should have been diagnosed earlier?

A. No.

Q. Why not?

A. I took care of their problem for them.

Q. Some of those patients die --

A. No.

Q. -- of cancer? None of them?

A. They did not.

Q. Okay. Do you think that would have been appropriate for you to tell them that their physicians should have diagnosed their cancer earlier?

A. I don't have an opinion.

Q. Pardon me?

A. I don't have an opinion on that.

Q. Did you ever talk to those physicians and say, "Hey, you should have picked this up a little earlier"?

A. Yes, I did.

Q. So you called the physicians and said, "Hey, you should" -- what did you tell them?

A. They were actually people who were radiologists who I brought it to their attention that there were things that were present on examinations that they had

not seen.

Q. All right. How often does that kind of thing happen?

A. Not very often. It's rare.

Q. What's your current practice?

A. Urology.

Q. Can you describe, is it a general urology practice?

A. It is not.

Q. What is it, then?

A. It's an academic urologic practice that focuses on cancer.

Q. What does that mean, an academic urologic practice?

A. It means I have other responsibilities other than caring for patients.

Q. What are those?

A. Teaching and scholarship.

Q. What do you mean by "scholarship"; research?

A. That would be one aspect.

Q. What else?

A. Writing. Advising. Advancing the specialty.

Q. What percent of your time is devoted to actual clinical practice?

A. Probably an estimate would be, at the present

time, 85 percent.

Q. And what percentage of your time is devoted to teaching?

A. It's difficult to -- for me to say in a compartmentalized way what percent is teaching because much of the teaching I give is to residents who are in training, and much of that occurs while I'm delivering care to patients, and so there's overlap.

Q. There's an overlap, yeah.

A. It's unusual for me to be involved with patient care when there is not a resident involved. But there are specific teaching things that are done that are absent of patient care, such as our X-ray Conference and Indications Conference that starts at 5:00 tonight.

Q. Don't suppose we could sit in on that, could we?

A. You'd be welcome to.

Q. Okay. You said that it's an academic practice, did you say focusing on cancer? I don't want to --

A. I'm not sure the adjective I used, but that's what I meant.

Q. Okay.

A. I do work pretty much exclusively in the area of cancer, not 100 percent.

Q. Do the -- what kind of a patient load do you

have?

A. Well, I generally see in the office every week somewhere around a hundred patients, and I operate pretty much all day on Wednesdays and Fridays. And that's over and above the office practice, which is Monday, Tuesday and Thursday.

Q. All right. And is yours primarily a referral practice, would you describe it?

A. Yes.

Q. Do the majority of your patients present to you already with a diagnosis of cancer?

A. I think so, yes.

Q. Are the majority of your patients referred by other urologists?

A. I actually think many of them end up seeing me with their diagnosis made because of the James Cancer Hospital and the fact that I'm head of Urology there, and so as much as I'd like to think they come to see me, I think they're really there because of the cancer hospital and I happen to be the urologist.

Q. Okay. So most of them are going to the hospital with a diagnosis of some sort of cancer already, and then if it's in the field of urology, they get to you; is that fair to say?

A. I think that's fair.

Q. Are you an oncologist?

A. I treat people with cancer. I do not have a board certificate -- I treat people with cancer.

Q. Are you an oncologist?

A. Yes.

Q. Okay. And what makes you an oncologist?

A. I treat people with cancer.

Q. Any board certification in oncology?

A. In medical oncology, no.

Q. Are you board certified in some other type of oncology?

A. I am board certified in urology.

Q. Okay. Do you belong to any oncology societies or associations?

A. Yes.

Q. What are they?

A. I'm a member of the Society of Urologic Oncology.

Q. Any others?

A. I'm a member of the American Association of Cancer Research.

Q. Anything else?

A. The American Urologic Association, which has a large portion of its activities devoted towards cancer of the genitourinary system.

editors of that text.

Q. Is that one that you have ever read or had ever read any parts of it?

A. Yes, I have.

Q. Do you have it here in your office? I didn't see it over there.

A. Then we probably don't.

Q. Okay. Is this conference room that we're in -- there are a number of books here, what, is this the library for the Urology Department?

A. It is.

Q. And who picks the books that go in here?

A. At the moment we don't have anyone picking the books. We're not adding to the collection at the moment.

Q. Okay. When did you stop adding?

A. I suppose when I came here to become the chairman.

Q. Okay. When that?
A. In September of 1996.
Q. And why did you stop --
A. Well, books are about two years out of date the first day they're published, No. 1.
No. 2, we have a great library that's about 200 yards from here, so if anybody really wants to look something up in a book, they can do that.
And thirdly, reimbursements to the hospitals and physicians are down substantially over what they used to be, so we're trying to cut corners where we can.
Q. Okay. Did you say that books are two years out of date by the time they're published, medical texts, generally?
A. That's correct.
Q. Would that go for your books, the ones you've written as well?
A. Yes, they would.
Q. Okay. So why do you write them?
A. I asked myself that same question after I completed my book.
Q. Okay. Do you know Dr. Neil Rosen?
A. I do not.
Q. Have you ever heard of him?
A. Never. Excuse me, that's not true, I have

Q. Is it your practice to, as far as urology films, to read all the films on your patients yourself?

A. No.

Q. Okay. If you don't read them, do you defer to the radiologist reading them?

A. In some cases.

Q. How do you determine whether you're going to review films in a particular case or you're going to defer to the radiologist?

A. Don't have a set outline of rules of when I do and when I don't.

Q. Do you feel that, as far as urological x-rays or other kinds of radiology studies, you're as competent to read them as a radiologist?

A. In some cases, yes.

Q. What cases would those be?

A. Well, examples, not an exhaustive, exclusive or all-inclusive list, I would say that excretory urograms, retrograde ureterograms, voiding cystourethrograms, ultrasounds, cat scans.

Q. In all of those areas --

A. Retrograde pyelograms.

Q. I'm sorry.

In all of those radiologic studies that you just mentioned, you feel that you as a urologist would

be just as competent to read them as a radiologist; is that fair to say?

A. I don't think I would agree with that statement.

Q. Okay. What don't you agree with about it?

A. I think that competence, when it comes to reading x-rays, is a difficult issue to judge, and until there is some means by which you can quantitatively make that evaluation, that it would be pointless for me to place myself in some comparison with radiologists.

Q. When you say "quantitatively" evaluate, you mean test in some way; is that what you're referring to?

A. That would be quantitative.

Q. Okay. Do you have to read films as part of the urology boards?

A. Yes.

Q. Would you say that's sort of a test?

A. It is a test.

Q. How much of the urology boards is radiology, reading radiology?

A. The only way we could decide a percentage is to take a look at the total numbers of hours of testing, and the qualifying exam I believe is a total of six hours, and **I** think the radiology and pathology are each an hour, and I think your oral -- you have two oral

examiners, each of those being an hour.

So I suppose it would be about a sixth or a seventh of the total exam was radiology in terms of annual radiologic exam. Although on your oral examinations you are given images that you must interpret, and on the written exam there are sometimes reproductions of films that you're asked to interpret.

Q. One of the things you do with your residents is go over films and ask them to interpret them and then you check their interpretations?

A. Yes.

Q. Now, you get paid by your corporation, is it by the Surgery Corporation; is that right? That's who gives you your paycheck?

A. No. I earn my paycheck.

Q. Okay. Well, when you earn it, who gives it to you?

A. I suppose I do.

Q. All right. What's the check say on it? Who's it from?

A. Well, I actually get two of them, one from The Ohio State University, and I imagine that's signed by the treasurer, but since it's a direct deposit, I never see a signature.

Q. Okay.

A. And I also get a direct deposit from the Department of Surgery Corporation. I imagine that's signed by our executive director or the president of the corporation, but I don't see those either.

Q. All right. When you get a check for a medical malpractice case, is that your income or do you turn that over to the Department of Surgery, or to Ohio State, or what?

A. That's my income. I do not turn that over to either Ohio State or the Department of Surgery Corporation.

Q. Okay. How does that stack up in terms of percentage of your income, your medical malpractice involvement as an expert?

A. Well, I know it would be less than 10 percent, and I think it's probably less than 5 percent, but I don't know that for sure. I'd have to go back over my tax return.

Q. Okay. Now, in this case that we're here about you wrote a letter on July 14th, 1999, to Mr. Norchi, correct? We'll mark that as Exhibit 1 for your deposition.

A. Yes.

Q. And your testimony in this case is going to be about the care of Dr. Siminovitch; is that right?

A. Yes.

Q. You're not offering any opinions about the care of Dr. Luria, correct?

A. Correct.

Q. You're not offering any opinions about the care of the radiologist, correct?

A. Correct.

(EXHIBIT MARKED FOR IDENTIFICATION.)

Q. We've now marked this as Exhibit 1, Deposition Exhibit 1 with your name on it. Would you, for the record, identify that, Doctor?

A. Deposition Exhibit 1 Bahnson.

Q. What is it?

A. This is a letter which I sent to Mr. Norchi on July 14th.

Q. All right. And that contains the opinions and the basis for your opinions that you're going to offer in this case, correct?

A. Yes.

Q. What is it you were asked to do in this case?

A. Initially, I was asked to review the documents which he sent me -- Mr. Norchi -- and to render an opinion as to whether or not there was negligence on the part of Dr. Siminovitch.

Q. And you agreed to do that.

A. I did.

Q. And why is it you agreed to become involved in this case?

A. I was asked.

Q. Okay. When were you first contacted?

A. I don't recall.

Q. Do you keep a record of your time spent on the case so you can bill on it?

A. I do.

Q. Okay. Would there be a ledger indicating when you first got involved and spent any time on the case?

A. Not a ledger.

Q. What would there be?

A. There might be a copy of a bill that I sent him for the time that I spent.

Q. Okay. You have some materials in front of you. Is that your entire file on this case?

A. Yes.

Q. Can we go through and identify these?

MR. LANSDOWNE: May I?

MR. NORCHI: Yes.

Q. There's some clipped pages which are identified as Dr. Luria's office chart; is that right?

A. Correct.

Q. And you reviewed that.

A. Yes.

Q. And there's some clipped pages identified as Dr. Siminovitch's office chart; is that right?

A. Yes.

Q. And then there's stapled pages of documents identified as Luria/Pietrangelo, No. 10 957. Do you know what that number 101957 is?

A. I do not.

Q. Okay. And it's further identified on the first -- on this cover page as University Hospitals Admission 1/22 - 28/96, right?

A. Correct.

Q. And there's stapled pages Luria/Pietrangelo, No. 101957, University Hospital Admission 10/22 - 25/95, correct?

A. Correct.

Q. And you reviewed that. Right?

A. Yes.

Q. And you also reviewed this next one that is similarly identified and is University Hospitals Admission for 6/12 - 6/15/95, correct?

A. Yes.

Q. And you reviewed that.

A. Yes.

Q. And there's some pages that are identified as

pathology reports, and you reviewed those as well?

A Yes.

Q And you reviewed the report of a Dr. From Kuyt; is that correct?

A Yes.

Q And the report of a Dr Mrs Barnett, correct? Do you recall that? Here it is here (indicating)

A Yes.

Q And as you mentioned before, the report of Dr. Neil Rosen, correct?

A Yes.

Q When there's a brown volume of records indicated Medical Records 10/7/88 through 10/27/93; do you see those?

A Yes.

Q And you reviewed those

A Yes.

Q And some bound records identified as University Hospitals Outpatient Records

A Uh-huh

Q. It's better if you said a "yes," Doctor.

A Yes.

Q And you reviewed those as well

A Yes.

Q In University Hospitals Admission 2/3 -

2/14/95, you reviewed those as well.

A. Yes.

Q. And did you review Dr. Luria's deposition?

A. Yes.

Q. Okay. Have you now identified all of the material that you reviewed in this case?

A. Yes.

Q. Have you looked at any films in this case?

A. Yes.

Q. Okay. And do you still have them in your file, or did you send them back, or what?

A. I actually saw them for the first time today.

Q. Oh. Well, what films did you see today?

A. I saw the -- two CT scans, one which was done at the time that there was a percutaneous aspiration of the cyst, and I believe that was in 1988.

Q. Correct.

A. And then a CT scan of the kidneys that I think was done at University Hospitals, and I believe that was -- I'm sorry, I don't recall the date. It was in the '90s, '93, somewhere.

MR. NORCHI: '94.

Q. '95?

A. '95, sorry.

Q. It's quite all right.

Okay. And did you make any notes about your review of those films?

A. No.

Q. You saw them for a couple minutes today; is that it?

A. Yes, a few minutes.

Q. Okay. Well, since it's not in your report, I don't expect you're going to be offering any opinions about those films; is that fair to say?

A. Oh, I could offer my opinion about the films if you wanted me to.

Q. Well, is it different from your opinions in your report?

A. It doesn't change the opinions in my report.

Q. It's an additional opinion? Or, additional opinions?

A. It supports my conclusions that I reached in my report.

Q. Did you ever ask to look at those films before today?

A. I did not.

Q. Okay. You'd seen the reports of those films before, correct?

A. Yes, I had.

Q. Having reviewed the films now, do you agree

with the radiology reports that go with the films?

A. I haven't reviewed the films alongside the reports, so I don't think I have a major change in terms of what those are based on my review from some time ago, but I didn't go through and compare them side to side.

Q. Did you look at any medical literature in coming to your conclusions in this case?

A. I did.

Q. What did you look at?

A. I looked at the Bozniak classification for cystic lesions of the kidney.

Q. Did you look at an article by Bozniak or did you look at the classifications independent of the article, or what did you look at exactly?

A. I looked at the, I'd say uroradiology textbook that summarizes -- his original article I believe came out in a radiology journal in I think the mid-'80s, '85, '86, somewhere around there, and I did not review that, what I reviewed is the Textbook of Uroradiology.

Q. What textbook?

A. Oh, it used to be called Emmett's Clinical Urography, now it's called Howard -- gosh, I should know, I'm an author in the stupid thing. Clinical Urography I think is the title of it.

Q. Where did you look at it?

A. I have a copy in my office of that text.

Q. What's the date of that text? Do you know?

A. I wouldn't know. I'd have to look it up. It's got to be sometime in the late-'80s because what I wrote for it was in '86, I believe.

Q. What did you write for it?

A. I wrote a section on radiography of bladder inflammation, I believe.

Q. Any other literature besides that, the Bozniak classifications in that text that you looked at?

A. None that I specifically recall.

Q. Okay. What about any of your own literature, did you go look at any of that material?

A. I read the literature almost daily.

Q. I meant things that you authored, did you go look at any of your publications?

A. In reference to preparing my opinions about this case?

Q. Yes.

A. No.

Q. Okay. Is there anything that you've written that is of any particular relevance to the issues here?

A. Not that I recall.

Q. Okay. Are you aware of other literature besides the article that you looked at in the text that

'you've identified that would be relevant to the issues that are presented in this case?

A. I would imagine that we could fill this room with articles that are written about the issue that is being brought up by this particular case.

Q. What do you think the issue is that's being brought up by this particular case?

A. It's a clinical issue that we as urologists struggle with, which is how far do you go when you are trying to prove or disprove the presence of a malignancy?

Q. I notice in this conference room, which is also the Urology Department library, you have Campbell's -- at least two different versions of Campbell's Urology; is that correct?

A. Well, there's at least two that I can see from here, there may be more. One of them's quite old and one of them is old.

Q. All right. Do you know how many -- well, strike that.

Is Campbell's a fairly widely utilized text in the field of urology?

A. Yes.

Q. Would you say it's authoritative?

A. No.

Q. Okay. Because no text is authoritative?
A. That is correct.
Q. Including your own.
A. Very definitely.
Q. Okay.
(Interruption.)
Q. Is Exhibit 1 the only report that you've prepared in this case?
A. To the best of my recollection.
Q. Were there any drafts of the report?
A. To the best of my recollection, no.
Q. And what did you understand this report to be? What did you understand the purpose of your writing the report was?
A. To convey my review of the materials and my opinion based upon my knowledge, my expertise, my experience, that in this specific situation Dr. Siminovitch did not fall beneath the standard of care in terms of his treatment of this patient.
Q. All right. Let me ask you about kidney cancer. And that's one of your areas of specific interest, I assume, correct?
A. Yes.
Q. Is early diagnosis of kidney cancer important?
A. It may be

Q. It might not be?

A. Yes, it might not be.

Q. In terms of determining survival of a person with kidney cancer, what are the factors?

A. The accepted factors are stage and grade and performance status of the patient.

Q. And does stage and grade have anything to do with the timing of the diagnosis?

A. I would say in terms of stage, yes. In terms of grade, possibly.

Q. What is the treatment for kidney cancer?

A. There are several.

Q. What are they?

A. No treatment, surgery, radiation, chemotherapy, immunotherapy. That would be it.

Q. In terms of survival of the patient, what's the most successful treatment?

A. Surgery.

Q. Is surgery the only treatment that offers a better than 50 percent chance of survival with kidney cancer?

A. No.

Q. No? What other treatments would offer a better than 50 percent chance of survival?

A. I'm pretty sure it's Dr. Bozniak who reported a

'number of patients who lived long periods of time and they had no treatment whatsoever.

Q. Do you recommend no treatment for kidney cancer very often in your practice?

A. How often would be "very often"?

Q. I don't know. Just, you know, English. How often is "very often" to you?

A. I would say that that's a small percentage of patients that I recommend no treatment, but it's not rare.

Q. And are these patients you expect to survive?

A. Yes.

Q. For long periods of time?

A. And how long is "long"?

Q. More than five years.

A. Yes.

Q. Okay. Is this renal cell cancer that we're talking about, or are you just talking about all kidney cancers?

A. I was referring actually primarily in this discussion to renal cell cancer.

Q. Okay. I'm sorry, were you finished?

A. Yes, I was finished.

Q. In your report you make a statement that "...there is no proof, either by pathologic specimen or

'by autopsy, that the patient had a renal cell carcinoma." That's part of your report, correct?

A. It is.

Q. And when you say there's no pathologic specimen, you mean there's no specimen of the actual kidney tissue or tumor tissue in the kidney; is that what you're talking about?

A. That's one part of it.

Q. And the other part being because there was no autopsy at all, correct?

A. Correct.

Q. Now, is it your conclusion that you're unable to tell what kind of cancer Mr. Pietrangelo had?

A. That is my conclusion.

Q. So you have no opinion, with reasonable medical probability, as to whether or not Mr. Pietrangelo had renal cell carcinoma; is that correct?

A. You'll have to ask that question a different way.

Q. Okay. Do you have an opinion, with reasonable medical probability, as to whether or not Mr. Pietrangelo had renal cell carcinoma?

A, I don't have an opinion.

Q. Okay. Can you tell me what's the most common site for renal cell carcinoma to metastasize to?

A. Yes.
Q. Would you?
A. Lymph nodes.
Q. Is there a common progression as far as metastases for renal cell cancer?
A. No.
Q. Is there a common growth pattern for renal cell carcinoma?
A. No.
Q. In other words, it can grow slowly for periods of time and then quickly for periods of time, correct?
A. Correct.
May **I** just modify that statement?
Q. Certainly.
A. Because I know of lesions that -- in patients that I've cared for or read about that it progressed quickly and **I** know about lesions that have progressed exceedingly slowly. I have never cared for a patient nor have **I** ever read about a patient in whom the same tumor was seen to grow quickly at one stage and then very slowly at another time.
Q. You've never read about that?
A. Correct.
Q. And do you think that happens?
A. I wouldn't be surprised if it could, I just

Q. Okay.

A. Okay. Now, you're asking me to assume ha he died of renal cell cancer and then, if I understand your question correctly, you then want me to go back and look at what Dr. Siminovitch did when he saw the patient, I believe it was back in 1991; is that correct?

Q. And '2.

A. And '2. And you're going to ask me is that going to change my opinion about whether or not he met the standard of care or didn't meet the standard of care.

Q. Right,

A. And my answer to you is, is that it does not change my opinion.

Q. Okay. The reason I ask it is because your report said "I base my opinion on the following things" and then you say "First of all, there is no proof, either by pathologic specimen or by autopsy, that the patient had renal cell carcinoma."

So your letter seems to say that part of your basis for believing that Dr. Siminovitch was not negligent is the fact that you don't have this proof that Mr. Pietrangelo had renal cell carcinoma. Is that what you meant to convey in this letter?

A. I think it gets back to, you know, your

question to me earlier about what was my understanding about what I was supposed to do when I reviewed these documents. And so if he didn't have renal cancer and didn't die of renal cancer, then it seems to me that issues about Dr. Siminovitch are not terribly important.

Q. Okay.

A. Are you going to, in your --

MR. NORCHI: Did you answer the question, Doctor? Make sure you answer the question.

A. All right, why don't you repeat the question again.

MR. NORCHI: I think he answered it.

THE WITNESS: What was my answer to the question?

MR. LANSDOWNE: Do you want to read back as far back as he wants to have read back?

THE WITNESS: Just my answer, please.

(Answer read.)

A. Okay.

Q. And if he did die of renal cancer, then what?

A. Then the evaluation that he performed at the time when he saw him and the recommendations that he nade and the information that he obtained were sufficient, in my opinion, at that time to rule out the presence of the cancer.

Q. Okay. So what did he die of? Maybe he didn't die.

A. I'm not --

MR. NORCHI: I don't know, you filed the lawsuit.

A. I'm not sur I know from the information that was provided. I think he died of cancer. It certainly appears to me that something in his body was a malignancy and was spreading to other parts of his body, that's clear. The origin of that cancer is what I think remains in question.

Q. You just don't know what the origin of the cancer is; is that right?

A, That's correct.

Q. Okay. So it's possible it was the kidney, and it's possible it wasn't the kidney.

A. I think that's fair.

Q. Okay. Do you know what the physicians who were caring for him at University Hospital were identifying as the primary site?

A. **I** do.

Q. **And** what was that?

A. They were operating under an assumption that he had renal cancer.

Q. And did they have any reason to operate under

that assumption?

A. I think the physicians at University Hospital are good physicians, so I'm going to make an assumption that they did.

Q. Do you know Dr. John Murphy?

A. I don't.

Q. Are you aware from reviewing the University Hospital records that he was the oncologist who was taking care of Mr. Pietrangelo?

A. I'd have to re-review them to make sure that was the person. I know that there were oncologists who were attending him when he was there at the hospital, I don't recall the name.

Q. But you would not accept the conclusions of the University Hospital physicians that he was, in fact -- that he did, in fact, have a renal cell carcinoma.

A. That's correct, I would not accept that.

Q. Okay. But you wouldn't dispute it either, I guess.

A. I think that what I agreed to is that it's possible that he had renal cell cancer.

Q. Just as likely that he had it as he didn't?

A. I don't think I would agree with that.

Q. In order to have -- in order for you to be convinced that he had renal cell carcinoma, there would

have to be either a pathologic specimen or -- taken while he was alive or at autopsy, correct?

A. You could exhume him, I guess.

Q. Well, that would be by autopsy.

A. I'm not sure exhumation qualifies as a postmortem exam. Perhaps you're right, but --

Q. I am. I've done it.

A. Okay. Then I'll --

Q. So accept that, will you?

A. I will accept it.

Q. All right. So what you need is pathologic specimen or specimen at autopsy in order for you to conclude that a patient had renal cell carcinoma; is that right?

A. Yes.

Q. Okay. Does renal cell cancer metastasize to the lungs?

A. It can.

Q. Is that a common site of metastases?

A. It is.

Q. What is -- I don't think I can pronounce this, maybe can you help me. M-u-c-i-n.

A. Mucin?

Q. Yes.

A. It's a lubricant,

Q. What does the absence of mucin mean with respect to -- when you're trying to determin wha kind of cancer cells you're looking at?

A. Certain cells in the body will typically produce mucin, and if you're looking at a cancer and you don't know where it came from, sometimes you check to see whether or not those cells are producing any of a number of substances, mucin happening to be one of them, and if they do produce that, then it heightens your suspicion that that's where the cancer came from.

Q. What about the kidneys, do they produce mucin?

A. Typically, no.

Q. Okay. So the absence of mucin might support a finding of renal cell cancer?

A. It could.

Q. Did you read the report of a Dr. Green in this case?

A. I don't recall reading a report of a Dr. Green.

MR. NORCHI: I'll represent to you, Dennis, I did not send him a report of a Dr. Green.

MR. LANSDOWNE: Okay.

Q. You did read Dr. Siminovitch's deposition, so let me ask you a few things about that.

Dr. Siminovitch says that the methodology or

modalities of differentiating between benign and malignant renal masses have b en fairly constant over the years. Would you agree with that?

A. What period of time are we talking about?

Q. Well, let's say from '88 through '92.

A. I would agree with that.

Q. Okay. What about from '92 to the present?

A. What does "relative" mean?

Q. You mean when I said -- I don't think I said "relatively." I said "fairly constant."

A. Okay, what does "fairly" mean?

Q. Well, have there been significant changes?

A. What does "significant" mean?

Q. Okay. You don't think you can answer that question as I've stated it?

A. I just know that words are very important to you much more so than they are to us in the medical profession, so I'm seeking clarification of your definition.

Q. No problem with that, I'm just trying to get an answer, and if you can't answer that, then that's fine. As long as you answer the same way when you come to trial, right? You're going to answer the same way when you come to trial as you're answering here, right?

A. I'll do my best.

Q. Okay. Because I'll remind you if you don't, okay?

A. I imagine you will.

Q. You mentioned Bozniak, is that a -- the Bozniak categories, is that something that you use in your practice?

A. Yes.

Q. Okay. I imagine, as we discussed before, the people that come to you have already been diagnosed with cancer, so you're not as often put in the position of trying to differentiate between a benign cyst and a malignant cyst; would that be fair or not?

A. Actually, I think the opposite is true. I think that for this particular situation where there is questions about whether or not a complex renal mass is cancerous or not, I think I actually tend to see that more than someone who's in a more general practice of urology.

Q. Okay. So before when I was asking you about whether the people that you see had more often than not already been diagnosed with cancer, that's not actually accurate?

A. Oh, no. On the contrary. It's exceedingly accurate because most of the cancers that I see do have the diagnosis made, prostate, bladder, urethral, penile,

testicular cancer, those diagnoses. And many times the diagnosis of kidney cancer has been made. But I see many patients who are sent in because of a problematic situation in terms of trying to make a diagnosis for a lesion or mass that's present in the kidney.

Q. Okay. All right. Well, thank you, that clarifies that.

And you did say something about -- you did use the term "complex cyst." You differentiate between a simple and a complex cyst?

A. Yes, I do.

Q. And how do you make that distinction? What is the difference?

A. Well, a simple cyst is round, it has no internal echos, it has posterior acoustic shadowing behind it, the rim is not variegated, it's uniform.

Q. Anything else that would factor in?

A. No. I think that pretty much does it in terms of the ultrasonographic characteristics.

In terms of the CT characteristics, again, it's of uniform density, it's round, it does not have internal septations, and would be free of calcification.

Q. You mentioned a CT scan. If you are evaluating a known complex cyst with CT, you'd want to get a pre- and postcontrast study, I take it.

MR. FOGARTY: Objection.

A. If I were evaluating a complex cyst.

Q. Yes.

A. I'm the first person to see this patient?

Q. What difference does that make? Or, does that make a difference?

A. Yes.

Q. Okay. What is the difference?

A. I just needed to work through what I do and so I need to have you --

Q. Okay.

A. -- spell out the circumstances. I'm seeing a patient for the very first time, and they arrive in my office, and what they have had done is a sonogram of the kidney? And that shows a complex cyst.

Q. Or they have a complex cyst that's been identified by CT.

A. Okay. Well, probably if they've had the CT, then oftentimes what I will do is get a sonogram, because I think the studies can be complementary, I really utilize them both.

Q. All right. Well, if you're going to use a CT to evaluate a cyst, a complex cyst, I'm just asking about the CT itself, would you want to get a pre- and postcontrast study?

MR. FOGARTY: Objection.

A. It would depend on the circumstances and the patient.

Q. Okay. Under what circumstances would you not want both a pre and post?

A. I wouldn't want to do it in somebody who had a contrast allergy.

Q. Okay.

A. Wouldn't want to do it in somebody that had a history of hyperuricemia or uricosuria. Wouldn't want to do it in somebody who had preexisting renal dysfunction. You wouldn't want to do it in somebody who had had previous contrast, nephropathy. So just good practice of medicine, rule out the people in whom doing that could be injurious to them.

Q. All right. But I mean, in terms of diagnostics, other than somebody who's not a candidate for that under any circumstances, wouldn't you want to get both?

MR. FOGARTY: Objection.

A. Again, I'm going to say that it would depend a little bit upon the situation. I think in many cases what you describe is what I do. I do, when I do a CT, get pre- and postcontrast if there's no clinical contraindication to doing that.

Q. Was there any clinical contraindication for Mr. Pietrangelo at any point that you're aware of?

MR. FOGARTY: Objection.

A. I don't think there was, to my review.

Q. And the reason that you in your own practice use a pre- and postcontrast study is what? CT study.

A. Well, a number of reasons, because the two studies give you some different information. The precontrast study really is devoid, for the most part, of functional information about the performance of the kidneys in terms of doing the job they do.

And when you give contrast, that does give you a lot of information about how the kidney operates; is it getting good blood? Is it getting there on time? Is it getting there at the same time that it does to the other kidney? Is it getting filtered appropriately? Is it washing through the cortical medullary junction at the appropriate times? Is it being excreted in a timely fashion into the collecting system?

I mean, all of those are bits of functional information, so -- and then if you're trying to -- it also can help you with anatomical information in terms of giving you a differentiation of the density of the kidney before and after you give a contrast.

Q. In the issues that we're talking about here,

differentiating a benign from potentially malignant lesion in the kidney, what is the importance of pre- and postcontrast study?

MR. FOGARTY: Objection.

A. Sometimes it's important and, unfortunately, sometimes it's not helpful, and even more unfortunately, sometimes it can misdirect you.

Q. Well, does a pre and post give you some information about enhancement within the kidney?

A. It does.

Q. And is that an important thing to look for?

A. Can be.

Q. And is that something that, you know, in the Bozniak article is discussed; do you recall that?

A. No. Not directly, The Bozniak classification really gives you much -- is broken down into four categories more on anatomic information than it is on functional information.

Q. I'm talking about the portion of the text that you read, do you recall any discussion about the value of pre- and postcontrast study?

A. I don't recall.

Q. Do you recall a discussion about the possibility of contrast obscuring calcification in a cyst?

A. I don't recall that discussion.

Q. Okay. Is that something you're familiar with, the possibility of contrast obscuring calcification in a cyst?

A. Yes.

Q. Okay. Would that be one of the reasons to get a precontrast study, so you don't obscure calcification within a cyst?

A. It could be a reason, yes.

Q. In your teaching of residents -- well, let's just make a hypothetical. If a resident came to you and said, "We have a patient with a complex cyst in the kidney and we want to have it evaluated by CT," the resident asks "Should we get a pre- and postcontrast study?" what would your answer be?

MR. FOGARTY: Objection.

A, I don't want to be repetitious, but we'd go through that little discussion about issues related to any risk in getting contrast.

Q. Right. And if that was not -- if there was no medical contraindication?

A. Okay. And then I would want to take a look at the ultrasound with them.

Q. And if there hadn't been an ultrasound?

A. But he's telling me that he has a complex

Q. You mean there can be less contrast as time goes by? Th contrast is less effective for the CT --

A. No.

Q. -- from the time that it's given?

A. No.

Q. What's the timing difference?

A. How can I explain this?

If you were defending somebody or prosecuting somebody who was involved in an automobile accident and you had somebody that filmed that accident with a still camera that took pictures at 20 frames per second, would you have an easier time understanding what took place at that accident than if somebody had been there with a Brownie camera and took one single photograph of that accident?

Q. I guess I'd have an easier time with the taking serial pictures over --

A. Would you agree that there's more information in the, you know, because you've got 400 pictures to look at than just 1?

Q. I feel like I'm being deposed here.

A. I'm sorry, I'm just trying --

Q. It's all right. I agree with you. I was talking about the timing in terms of the contrast.

A. I wish I -- I'm failing at my job of teaching

here, because I try and educate the residents how important this is.

The contrast material appears in the kidneys and in the body. It's a dynamic event. You inject this contrast and it goes to the heart and then it goes through the heart and to the kidneys, and then the kidneys filter it and it's excreted, and ultimately it ends up in the toilet bowel. Depending on the point in time in which you get those images, there's different information that you get, and it's different because the contrast is in different locations at different times.

Q. And when is the optimum time to try and get information about a cyst in the kidney?

A. Okay. I think optimally I'd like to be the guy that's sitting there with the camera that's taking, you know, 400 -- or, 40 frames per second. I think if money was no object and I could afford to do whatever I wanted to, I'd love to be in a situation, and technology would permit me, I'd like to get an acquisition of an image in those kidneys every second, because I think there would be more information than if **I** got it every minute, which is -- **I** mean, actually we get them faster than that now, but it used to be.

Q. What about optimally in terms of the time period from the administration of the contrast?

A Well, the most information you can get is having an image before the contrast is given and then getting a series of images obtained immediately after the administration of the contrast, and then at some point getting delayed images

Q Okay. So you do aspiration of cysts? Kidney cysts.

A. Do I personally do them?

Q. Yeah.

A. Percutaneously?

Q. Yes.

A. No.

Q. Is it done here at the hospital?

A. Yes.

Q. Who does it?

A. The radiologists do that.

Q. Is that something that you order, you order for your patients occasionally?

A. Rarely.

Q. If a urologist is trying to determine if a malignancy exists, is it appropriate to aspirate a septated cyst?

MR. FOGARTY: Objection.

A. It is appropriate.

Q. Under -- why would you aspirate a septated

cyst?

A. You might do that to ascertain what the content of the cyst fluid was.

Q. If it's a septated cyst, aren't you only going to get the fluid from one of the septations?

A. If they're noncommunicating cysts, yes.

Q. And if they're noncommunicating, would you still do an aspiration?

A. Would I personally?

Q. Yes.

MR. FOGARTY: Dennis, are you talking now or in 1988?

Q. Make a difference?

A. For me it probably would not make a difference between now and 1988.

Q. Okay, then what's your answer?

A. Most likely would not.

Q. Why not?

A. When I practice with these kinds of situations, what I tell patients is if we do an aspiration and we get malignant cells, that that tells us something that's very valuable and useful, and unless we get malignant cells, unfortunately, it does not tell us that there isn't cancer.

Q. All right. Now, you said you saw the -- well,

let me ask you this: How big was the cyst in Mr. Pietrangelo in 1988? And feel free to look at your records.

A. I would have to review them. If you --

Q. Go ahead.

A. If you have the report there and can share it with me, it would save some time.

MR. FOGARTY: I have it.

Q. Which report do you want to look at, Doctor, to answer that question? The CT scan or a report, or the IVP report, or what?

THE WITNESS: Would you read back his question to me?

(Question read.)

A. I'd want to read the results of the CT and the ultrasound from 1988.

Q. Okay. Well, we've got in front of you the results of the 1988 CT scan, which has been marked as Deposition Exhibit C, I guess in Dr. Barnett's deposition. Is it your understanding that an ultrasound was also done --

A. No.

Q. -- in 1988?

A. No.

Q. Okay.

the accepted standards of medical treatment by evaluating the patient and he performed follow up studies which were not suggestive of renal malignancy." I'm just reading from your report so we can ask some questions here.

Now, by "evaluating the patient", what do you mean by that?

A. History and physical examination, and laboratory and x-ray studies.

Q. Okay. So he got a history, correct?

A. Yes.

Q. And what did that history involve?

A. Talking to the patient, asking questions and learning about what had been done in terms of previous urologic evaluations.

Q. And what you know about what he got out of the history is obtained in the 11/14/91 note of Dr. Siminovitch, correct?

A. Yes, and I believe I read his deposition as well, and there may have been some amplification of that in the deposition.

Q. All right. Did Dr. Siminovitch look at any of the previous radiology studies that had been done?

A. My recollection is he did not.

Q. Okay. What's your practice?

A. My practice varies. Sometimes I will ask patients to rescue those old images and bring them back so that I can look at them, and in some cases I don't, and it depends on circumstances.

Q. Did Dr. Siminovitch look at any of the radiology reports?

A. I believe that he did.

Q. You believe that based on what?

A. My review.

Q. Of what?

A. The deposition and his notes.

Q. What about his notes leads you to believe that he reviewed the radiology report?

A. He describes that he had an IVP, and had it aspirated and it proved to be benign, and this was all done at Hillcrest Hospital, and I made an assumption that he most likely was reviewing a report in order to get that information. Most of the time patients don't give you that information themselves.

Q. Well, this would have been -- 11/14/91 would have been the first time he saw this patient; is that your understanding?

A. Yes. I believe that's correct.

Q. Okay. And he says he apparently was found to have this two years ago, 1 guess referring to the

hematuria, and at that time had an IVP which apparently showed a type of renal mass which sounds like a cyst. If Dr. Siminovitch was looking at the IVP report, you don't think he would say the IVP apparently showed some type of renal mass which sounds like a cyst, do you?

MR. NORCHI: Objection. If you can answer, go ahead.

A. I don't know the answer to that question.

Q. And he says apparently had it aspirated and it proved to be benign, correct?

A. Correct. That's what it says.

Q. All right. So Dr. Siminovitch then advised the urine cytology and another IVP; is that right?

A. Yes.

Q. And those were performed, correct?

A. Yes.

Q. And then he ordered -- and Mr. Pietrangelo apparently followed Dr. Siminovitch's advice to have these studies done.

A. Yes.

Q. And then had a -- Dr. Siminovitch ordered an ultrasound or said he would obtain a diagnostic ultrasound, right?

A. Yes.

Q. And Mr. Pietrangelo again followed

Q. Did you see any septations in that cyst at that time?

A. My recollection is, is that I did, yes.

Q. You did see septations?

MR. NORCHI: Doctor, before you guess or recollect, I mean, because I don't know if you looked at them that long, you better look at them, this is important.

THE WITNESS: Okay.

Q. We don't have a box in here, do we?

A. Got one next door, or I can look at the ceiling.

MR. NORCHI: We'll try it here, and if we have to move, we will.

Q. Whatever you're comfortable with, Doctor. Just tell us what you're looking at there.

A. Okay. Now, this would be Plaintiff's Exhibit No. 1. Is that what that is?

MR. NORCHI: Charms, yes.

THE WITNESS: Charms?

MR. NORCHI: One - Charms.

A. And this would be the aspiration that was done, and this would not meet the criteria for a simple cyst based on -- I would not say that I see septations, but it appears that there's some calcification present

'within the cyst.

Q. Where within the cyst is the calcification?

A. It's in this particular panel, right here, which is Scan No. 5. And it's right there, a couple little dots there. These are reproductions.

Q. Is it in the --

A. There's also a calcification here in the image where the needle is actually seen to be penetrating into the cyst.

MR. SIGMIER: Which one is that?

A. Boy, that's a soft call, but there might be a septation in the scan No. 2. Might be a septation there. Okay, that's a soft call.

Q. What do you mean by a "soft call"?

A. Well, I think there are some septations that I would give a hundred percent agreement on and there's others that I wouldn't.

Q. So there might be a septation there and there might not.

A. That's fair, yes. Yeah.

Q. Now, I'm sorry, while we're on that, can you tell me where within the cyst the calcifications are? Is it in the wall? Is it -- and this is actually I think, I've been told --

A. A better --

Q. -- that it's a better quality, which is No. 2 - Luria.

A. Yeah, I agree. I think it is, too.

(Discussion held off the record.)

A. Boy, it's tough to call. Now, there is a -- they've changed the -- they've changed their settings here to try and emphasize calcification, and I'm not sure that's what they were doing, but you see here's the calcification, and in terms of saying whether that's in the cyst or the cyst wall, boy, that's tough. That's very difficult.

I think clearly on this image though, which is the one I told you about, Image 5, that they appear to be within the cyst itself. And that one image where I thought I saw a septation is not well represented on this. No, here it is right here, it's just a little question of right along the -- that's Scan 2, again.

Q. Right. Right.

A. Okay.

Q. Now, is that significant, where the calcification is within the cyst?

A. Well, some people would argue that it is, and in my -- some people would argue that that is of significance.

Q. How about you?

A. I don't really place a tremendous amount of emphasis on the calcification issues because, unfortunately, calcification in the rim of cysts has been shown to be associated with both benign and malignant lesions, and we're insufficiently precise with radiologic studies to be able to make that -- I mean, we're just never a hundred percent right.

Q. But if it's not in the rim of the cyst, if it's actually in the cyst, as you were indicating some of these images seem to indicate, that's a little more worrisome, isn't it?

A. I think it would have been if the density of that thing hadn't been so low on CT and, you know, that sort of, again, was another thing that pushed me in my direction and my thinking when I reviewed this, the Hounsfield units on that were 24 when they initially put him through the CT, and that had been done, I believe, on the, I think the same day that he had an IVP and there may have been, you know, some, you know, it may not have been a perfect -- in any case, putting together a number of 24, seeing something that looks very round like that, has a uniform low density on CT.

Q. Well, when you say "low density," 24 is not -- that's not zero.

A. I agree, it's not zero.

Q. And pure cyst fluid would be around zero, wouldn't it?

A. If it was pure cyst fluid and you had your cursor right in the middle of the lesion and the patient wasn't breathing and holding still and hadn't had contrast, yeah, you're right, it should be close to zero; if everything's perfect.

Q. And I guess the reason that, you know, you might be concerned about calcifications not within the rim of the cyst, but within the, I don't know if the center or the interior of the cyst, is that you're concerned that something must be holding those cysts up in that position in the -- or, that calcification in that position in the cyst; is that what the concern is?

A. No. I don't think so.

Q. What is the concern?

A. I think just if you look purely at numbers in terms of lesions in the kidney, if you look at ones that have calcium in them versus don't, the ones that have calcium, out of a thousand, more of them are going to have cancer than the ones that don't have cancer. So that's the concern.

Q. Okay. I was talking about the location.

A. I don't really ascribe a huge importance to that, and in particularly in this case I don't.

Q. In terms of Mr. Pietrangelo, in terms of making a determination of whether this is more likely benign or malignant, does the fact that it may have changed from nonseptated to a septated cyst, is that something that the urologist has to be cognizant of?

A. Well, I think you're cognizant of any changes that go on. I think more importantly here is that there's no solid lesion in this kidney by ultrasonography, and over a period of observation here of three years, and admittedly we're quibbling a little bit about what the exact size of this thing is, but by and large I think it's fair to say that it's not changing a lot in terms of its size. So I think, you know, those are important considerations,

Q. Had it gotten bigger from '88 to '91?

A. Well, if we assume that it's somewhere between 4 and 6-1/2, were those the numbers that we used --

Q. Yes.

A. -- from our previous --

MR. NORCHI: Doctor, this is the ultrasound report from '92, I don't know if that is additional information, but it had IVP and ultrasound and CT scan.

Q. Doctor --

MR. NORCHI: I don't mean to interrupt your questioning, by the way.

Q. Just answer my question.

MR. NORCHI: That's fair.

MR. LANSDOWNE: This is '92, and we haven't gotten to '92 yet. So can we go in --

MR. NORCHI: Order.

THE WITNESS: Order.

MR. LANSDOWNE: -- order, yes. Because he read the whole chart he knows the deal here.

Q. (By Mr. Lansdowne) Right?

THE WITNESS: Can I have his question repeated back to me?

Q. I'll just give you another question. Did the cyst grow from '88 to '92?

MR. FOGARTY: To '92?

MR. LANSDOWNE: '91.

A. 12/2/91, almost '92.

It remained -- did the kidney grow?

MR. NORCHI: No, the cyst.

A. The cyst.

Doesn't appear that it did.

Q. Okay. The IVP report says that it's somewhat -- that the cyst is somewhat larger.

A. Small.

Q. I'm sorry?

A. The IVP report?

Q. Yes.

A. I thc ght the IVP report was he one that had the low number, 4 to 5 centimeters.

MR. NORCHI: You said "larger."

Q. Let me --

A. The IVP had the lower number, the CT had the higher number, 6.5.

Q. No, I'm talking about the IVP that was done in '91. 11/18/91.

A. I'll have to see that report.

Q. The report.

A. I'll have to see that report, I'm sorry.

Q. This is the IVP report of 11/18/91, correct?

A. This is the one that Dr. Siminovitch did.

Q. Yes.

A, Siminovitch.

Q. Well, he --

A. He ordered it.

Q. -- ordered it.

A. He ordered it, thank you.

Okay.

Q. All right. Now, this notes that in comparing to it to the prior IVP, a mass was present at that time but it is now somewhat larger. That's what that report says, correct?

A. Correct. That's what it says.

Q. And you haven't seen any of the IVP films, have you?

A. I have not seen the IVP.

Q. All right.

A. I would point out to you that size of lesions using urography is subject to a lot of variation depending upon patient positioning on the table and how far the films are and so forth and so on. It's the, you know, the whole thing of the eclipse of the moon and the little dot on earth versus the big one shadowing it.

Q. So CTs a little -- because can you actually measure the lesion itself.

A. CT I think is, yes, is a more -- again, we talked about a perfect study, patient holding still, no motion, et cetera, et cetera, et cetera, but I think if I had to rely on a size measurement, I would put more faith in a CT, or an ultrasound, than I would an IVP.

Q. Okay. Now, I see that this -- the films that we've been looking at all contain a description and then an impression. Is that pretty much what you see generally with radiology reports?

A. It is.

Q. Okay. And is the impression the diagnosis of the radiologist?

MR. FOGARTY: Objection.

A. It's their impression.

Q. What does that mean, "their impression"?

MR. FOGARTY: Objection.

A. It's a -- radiologists seldom -- a radiologist interprets a film, and an interpretation may be suggestive of a disease process, but it does not diagnose a disease process.

Q. Okay. The impression is the interpretation?

A. Yes.

MR. FOGARTY: Objection.

Q. Okay. Now, the ultrasound -- well, we're dealing clearly with a complex cyst in 1991, correct?

A. Yes.

Q. All right. And it's been demonstrated as a complex cyst by both CT and ultrasound by 1991, correct?

A. In my opinion, yes.

Q. All right. Would you agree that with respect to kidney cysts, any lesion that on ultrasound is not clearly a simple cyst must be studied further by CT scan?

A. I would not agree with that.

Q. Okay. Why not? Have you ever read that before, that statement?

A. I may have. And I wouldn't argue that it

exists, in fact, it probably exists in a lot of places, but I don't agree with it.

Q. Okay. Is there any literature that you're aware of that disagrees with that?

A. My own experience disagrees with that.

Q. Is there any literature, medical literature that you're aware of, that would disagree with that statement?

A. I would imagine there is.

Q. You're not aware of any as you sit here today?

A. Oh, I'm aware of a New England Journal article on the approach to the renal mass written by Ralph Clayman that said CT was of no value whatsoever in working up renal masses. I don't happen to agree with that statement either.

Q. Right.

A. But I can find you literature that will support that, yes.

Q. So you're saying -- you don't know any as you're sitting here today that would specifically disagree with that statement, you're saying that you think you might be able to find something; is that right?

A. Well, yes, I think I can.

Q. Okay. Where would you look?

A. In the library.

Q. Where?

A. In the urology journals, in the radiology journals, in the urology textbooks and the radiology textbooks.

Q. Okay. So that's something that you plan on doing between now and your testimony?

A. No.

Q. Okay. So you're not going to have any of that literature when you come to Cleveland; is chat right? You're not going to have looked at any of that literature, right?

A. I might.

Q. Okay. So if you do that, would you tell Mr. Norchi what that literature is?

A. That's fair.

Q. Okay. Why do you -- excuse me.

Why do you disagree with that statement that any lesion that on ultrasound is not clearly a simple cyst must be studied further by CT scan?

A. Because there are many lesions that on ultrasound are not simple cysts that are benign that, if left alone, will never cause a problem for a patient.

Q. Is that it? Is there any other basis for your disagreement with that statement?

A. That's all that comes to mind at the moment.

Q. Okay. Do you think you'd have ordered a CT scan in 1991 after this ultrasound?

MR. NORCHI: Objection.

Q. Recognizing that you had a complex cyst with septations and recognizing that the radiologist had recommended a CT scan.

A. I would have, in my own mind, given him a Bozniak 2 classification of which my practice and recollection is that those people can be followed with repeat examinations over certain intervals of time, and I probably would not have done a CT scan. I probably would have had him come back at some interval of time that he and I could agree on to repeat this particular examination (indicating).

Q. Okay. And the Bozniak 2 would be based upon what?

A. Oh, that's a -- it doesn't meet those criteria for a simple cyst, but it doesn't have any of the solid components that raise concerns or worries about a cancer. It can or it cannot have calcifications and/or septations, and it can also, gee, if I recollect correctly, it may have some minimal enhancement if you do do a CT scan. And generally those are -- I would say I most always follow those with repeat exams.

Q. Okay. So despite the radiologist's recommendation -- well, let me ask you this: Would you have looked at the ultrasound yourself?

A. If it had been done in my hospital, I probably would have looked at it.

Q. If you didn't look at the ultrasound and the radiologist -- all you had to go on was the radiologist's report and the radiologist recommended a CT scan, you still wouldn't get it?

A. No. I wouldn't.

Q. Okay. Would you call up the radiologist and talk to him?

A. No, that's one thing that I -- I do do it, but it's pretty rare that I call somebody.

Q. If a CT had been done in 1991 following this ultrasound, what would it have shown?

MR. NORCHI: Objection. You can take a shot at it.

A. Don't have an opinion.

Q. Okay. Well, it certainly would have shown calcifications, right?

A. May not have.

MR. NORCHI: Objection.

Q. Why would it not have if they were present in '88?

A. It's possible that they may have gained access to the collecting system and were passed spontaneously.

Q. It would have certainly -- a CT scan would have certainly shown septations, correct?

A. If you believe the ultrasound, I would agree with you, it -- I think it would show those septations.

Q. And density, do you know what it would have shown about density?

A. I don't have an opinion.

Q. And what's your experience as far as calcifications? How often is it that calcifications are seen and then somehow leave the system?

A, It's probably more frequent that your slice interval through the kidneys on CT is such that you just don't catch it, but so I think passing it would be rare, but it can happen.

Q. Okay. If the calcifications that are seen on the 10/11/88 film are, in fact, in the wall, would that mean that the wall was a thickened wall of the cyst?

MR. FOGARTY: Objection.

A. Not necessarily.

Q. Okay. Why do you say that?

A. Because a calcification in a wall of a cyst is not **100** percent associated with a thickened wall of a cyst.

Q. I'm saying that on these calcifications that you see on 10/11/88, or on the 10/11/88 film, if those in fact are contained within the wall of the cyst, would that mean that the wall is thickened?

MR. FOGARTY: Objection.

A. I don't think so.

Q. Well, clearly they're not on the rim. The calcifications are not on the rim of the cyst, correct? ***So*** what I'm saying is, if we're seeing them and they are contained in the wall, that wall must be somewhat thickened.

MR. FOGARTY: Objection.

Q. Do you follow my question?

A. **I** think I see what you're getting at, and if what you're asking me to assume is, is that the inner lining of the cyst and the outer capsule of the cyst are on either side of the calcification, then the wall must be thickened.

Q. Right.

A. And the answer to that question would then be how thick is a thick wall, and how big is the calcification? And these are very small, minute calcifications, and I'm not sure, based on my interpretation, that I would say with certainty that they're in the wall.

that, no.

Q. Okay. It's certainly not in the report of the 10/11/88 study, the radiology report, correct?

A. Correct.

Q. All right. Now, in fact, Dr. Siminovitch apparently told the patient to come back for another study in 1991, correct?

A. I believe it would have been '92, because the study was 12/2/91 and he had proposed doing it some months later, so that would have been in '92, I think.

Q. Well, he had a cysto done in '91 after this --

A. Yeah.

Q. -- ultrasound, correct?

A. Oh, you were referring to having to come back to have the conversation for the cystoscopy.

Q. Just going in order.

A. I'm sorry, I thought you were talking about the radiologic study.

Q. No. He was told to come back and have a cysto, and he did, in fact, come back and have a cysto, correct?

A. You are, in fact, correct.

Q. And then the note of 12/17/91 showed that -- indicates that: The cysto showed no evidence of any abnormality to explain the microhematuria. I will see

him back in six months and reevaluate him at that time. Correct?

A. Correct.

Q. Okay. And Mr. Pietrangelo did come back in 1992 and was advised at that time to have a repeat ultrasound, correct?

A. Yes.

Q. And he did have a repeat ultrasound, correct?

A. Correct.

Q. And you have not seen that ultrasound film either, right?

A. Correct.

Q. But you have seen the report of that film, right?

A. Yes, I have.

Q. Okay. And again, if this --

MR. NORCHI: I'm trying to show it to you, but it's not a question, go ahead. I'm sorry.

MR. LANSDOWNE: We're in '92 now. We're at that point, go ahead and show it to him.

Q. They're very anxious that you see this, Doctor.

This would be Exhibit E.

A. Correct.

Q. Okay. Now, again, based upon what we've talked about before, if this ultrasound -- if you were

following this patient and an ultrasound had been done at your hospital, you would have gone and seen the film yourself, right?

MR. FOGARTY: Objection.

A. I said "probably."

Q. Okay. Probably in accordance with your usual practice, right?

A. No, I don't think I said that.

Q. I'm asking.

A. You're asking, okay.

My review of films on patients, actually we did talk about this, didn't we?

Q. Yes, that's why I was trying to -- I thought I understood it to be your practice to look at films like this when they're done in your hospital.

MR. NORCHI: That's not what he said, but go ahead, if you want to clarify it on the record, you can.

Q. If I've got that wrong, please correct it.

A. I think it is important.

Q. Okay.

A. Because I think there are times when I do, and there are times when I don't.

Q. Okay. And I was asking about with respect to this patient, Mr. Pietrangelo, if this was your patient, you were following him, would you likely have reviewed

this film? And you said with respect to the '91 film, if it was done in your hospital, you probably would have reviewed it.

A. Thank you, I think that is what I said.

Q. Okay. Now, with respect to this '92 ultrasound, if it was done in your hospital, would you have likely reviewed that?

A. Most likely not.

Q. And why not?

A. Because then at that situation -- hopefully, the radiologist who did this second ultrasound would procure the one that had been done earlier and would very carefully go through and compare the two of them.

Q. Okay.

A. And as long as I have assurances that in my hospital that's being done, then I'm less likely to go look at a repeat study than I am an initial one.

Q. Fair enough.

And what did the ultrasound report say about the -- what did the measurements show about the size of the cyst from comparing it to the previous film study?

A. Well, Dr. Gaglione measures it as being, I believe, an aggregate slightly larger than Dr. Kyung in terms of the cyst. The sides of the kidney, she now measures it as being quite different in terms of its

width, some 4 centimeters less in width than Dr. Kyung.

Q. I'm sorry, you said it's 4 centimeters less in width?

A. She says the right kidney itself measures 12.2 by 5.9, and Dr. Kyung said it measured 12.7 by 9, so -- I'm sorry, 3 centimeters. I can't add very well. Sorry.

Q. Okay.

A. She notes also that there is no solid mass in the kidney, either the right or the left. And then when she compares the study to the previous study that was done in December of '91, states in the body of the interpretation that the overall appearance is not significantly changed when compared to the prior study.

Q. Okay. So the measurements are somewhat different of the cyst itself, correct?

A. Yes. She measures a slight difference in the size of the cyst.

Q. Okay. So had it grown?

A. I would read and interpret this as not demonstrating a change in size. I think these measurements, if you had three or four different radiologists walk into the room and ask you to give them those three measurements, you could expect to see this degree of variation. So I would not attribute this to

a .. I would say it's unchanged in size. That would be my interpretation.

Q. Even though the numbers say it's bigger, you'd say it really hasn't changed.

MR. FOGARTY: Objection.

MR. NORCHI: Objection.

Q. I mean, because there's no arguing that the numbers do indicate, if you just went by the numbers, the numbers would indicate that the ultrasound that shows that cyst is somewhat larger, correct?

A. That is correct.

Q. Okay. And we have no CT scan during this period of time -- well, strike that.

Mr. Pietrangelo then calls in for the results of the ultrasound and his other studies, correct? That's what the notes would indicate?

A. Yes.

Q. And Dr. Siminovitch writes: I reassured him that his ultrasound had been unchanged. Correct?

A. Correct.

Q. Now, I guess technically that's not really true, is it?

MR. FOGARTY: Objection.

MR. NORCHI: Objection.

A. No, I think technically it's quite true. I

agree with Dr. Siminovitch.

Q. Didn't we just say that the numbers for the size of the cyst would indicate that the cyst is larger on 8/7/92 than it was in '91?

MR. FOGARTY: Objection.

MR. NORCHI: Objection.

MR. FOGARTY: Objection. Objection. Objection.

A. We agree for purposes of discussion that the numbers were different, and I say to you that that's fair, the numbers are different.

Q. Okay.

A. What I told you earlier is that I would interpret that as being no change.

(Recess taken.)

Q. What's your procedure here in your offices as far as following up with a patient who doesn't come back for an appointment?

A. We do not employ any calls or letters or things to remind people to keep appointments or that they missed an appointment.

Q. None whatsoever?

A. I think the only time that I've ever done that is there's a situation with young boys with testicular cancer who choose what's called an observation as

that cat scan agrees with the report.

Q. Well, your report doesn't say anything about whether or not there's kidney cancer in the -- or, there's cancer in the kidney in '91 or '92, does it?

A. The report does not say anything about that, that's correct.

Q. Okay. So that's -- when did you come to that opinion?

A. When I reviewed the materials initially before I wrote the letter back.

Q. Okay. Well, why didn't you include that in your report?

A. I don't know that I have an answer for that question.

Q. Okay.

(EXHIBIT MARKED FOR IDENTIFICATION.)

Q. How long have you been familiar with the Bozniak categories?

A. Define "familiar" for me.

Q. How long have you ever known anything about the Bozniak categories?

A. Probably the first time that I heard about them was when I was in Washington -- when I was in St. Louis at Washington University School of Medicine and Bruce McClennan, who is one of the people that was there in

I had submitted and he told me I was full of oats that had already been through a horse. So I do remember that.

Q. That would be something you'd remember, I guess.

A. Uh-huh, yeah. That was in 1984, I believe. So I've been familiar with Dr. Bozniak for a while.

Q. Okay. Well, in terms of the classifications for kidney cysts, do you recall when you first began using them?

A. I think it would have been in 1991. Right around there, '90/'91.

Q. All right. Take a look **at** this, Doctor. This is your Deposition Exhibit No. 2, it's a letter to James Casey dated August 20th, 1999 from a Dr. Green.

MR. NORCHI: I would object to the use, you can ask questions, but I understood that Mr. Casey withdrew Dr. Green and won't permit any of us to cross-examine him and he won't be testifying at trial, so I object to the whole exercise.

MR. POLING: Note an objection on my behalf as well.

MR. SIGMIER: I'll join in that.

MR. FOGARTY: Why not?

MR. SIGMIER: Objection.

MR. NORCHI: We have a quorum.

MR. LANSDOWNE: We got the grand slam? If I don't get one of those at deposition, I know I'm not doing my job.

Q. (By Mr. Lansdowne) Do you know Dr. Green?

A. I do not.

Q. Okay. Apparently, he's the Assistant Medical Director of Oncology/Hematology, Lake/University Ireland Cancer Center. He wrote an opinion letter in this case in which he stated that -- states that most probably carcinoma was present within the kidney at that time, referring to '88 and '92. And you would disagree with that?

MR. FOGARTY: Objection.

MR. POLING: Objection.

A. I would disagree with that, yes.

Q. He also says that "...the patient presented with a pathological fracture secondary to metastatic renal cell carcinoma and succumbed to his disease, after failing chemotherapy." With respect to that, you're just not sure whether or not he did have metastatic renal cell carcinoma, correct?

MR. POLING: Objection.

MR. FOGARTY: Objection.

MR. NORCHI: Go ahead if you can.

A. Correct.

(EXHIBIT MARKED FOR IDENTIFICATION.)

Q. This is Exhibit 3, it is a letter dated July 12th, 1999 from a Dr. Hamor, or Hamor, to Dennis R. Fogarty, and have you seen this before?

MR. FOGARTY: Just show an objection that, Dennis, I told you I was going to withdraw this witness. This Dr. Hamor won't be testifying at trial, won't be called by me anyway, but continuing line of objection.

MR. NORCHI: I'll join in the objection, but go ahead.

MR. SIGMIER: Likewise.

MR. POLING: Same objection.

Q. Let me know when you've had a chance to finish reviewing that, Doctor.

A. Okay. I've read this.

Q. Let me ask you about some statements that are made here. He says in the second paragraph, second sentence, that "We believe the workup in 1988 outlined above, including cyst aspiration which would not ordinarily be done today, meets the standard of care."

With respect to the statement that cyst aspiration would not ordinarily be done today, do you know what Dr. Hamor's referring to?

MR. POLING: Objection.

A. I don't.

Q. The next sentence says, "It was generally known at that time that a negative cyst aspiration does not entirely exclude neoplasm." Would you agree with that statement?

MR. POLING: Objection.

MR. NORCHI: You're talking relative to 1988?

MR. LANSDOWNE: Right, it was generally known in 1988.

MR. NORCHI: I would note an objection.

Q. That a negative cyst aspiration does not entirely exclude neoplasm; do you agree with that?

A. I do.

Q. And he goes on in the next sentence to say, 'This, in addition to CT scans which are not clearly a simple cyst, including mildly high density number machine dependent) and 'fairly sharp border,! should necessitate a heightened vigilance and follow-up." Do you agree with that sentence?

MR. POLING: Objection.

MR. NORCHI: Objection.

A. Well, first of all, he needs to go back to college and take rhetoric.

Q. We'll pass that on to him.

A. You can You can give him my card.

And secondly, I don't know what "heightened vigilance" means, so I don't have an opinion about that.

Q. Okay. "Subsequent follow and work-up in 1991, from the information provided, would seem incomplete."

MR. NORCHI: Objection.

MR. POLING: Objection.

MR. NORCHI: There's a question coming.

A, Disagree.

Q. Disagree with that.

MR. FOGARTY: Let me just note my objection and also that the letter doesn't indicate what was provided to the doctor.

MR. LANSDOWNE: Okay.

Q. And your disagreement would be based upon the testimony you've already given me in this case --

MR. SIGMIER: Objection.

Q. -- this afternoon, correct?

A, Yes, sir. Correct.

Q. Let me ask you, are you familiar with this text that's in **your** library here, this Clinical Urography, this is Volume 11, Saunders?

A. Yeah, I'm familiar with it.

Q. You testified in relation to tumor or calcification, and I want to ask you if you agree with these statements from this text.

Calcification in a renal mass on urography always raises the suspicion of malignancy; do you agree with that?

A. I'm sorry, would you repeat the statement, please?

Q. Yes. Calcification in a renal mass on urography always raises the suspicion of malignancy.

A. Yes, I'll agree with that.

Q. Would you agree that location of calcification in a mass is a helpful diagnostic point?

A. I would disagree.

Q. Central calcification in a mass on urography trongly suggests malignancy regardless of pattern of alcification; agree?

A. Disagree.

Q. What does "peripheral calcification" mean?

A. Calcification in the periphery.

Q. Meaning at the borders or edges of the mass?

A. I think that's fair, yes.

Q. CT evaluation of a renal mass should begin with nenhanced scans; do you agree with that?

MR. NORCHI: Objection. Asked and answered. o ahead.

A. Out of context, I'll have to disagree with hat.

Q. What do you mean, "out of context"?

MR. FOGARTY: Objection. Asked and answered.

A. You're reading to me statements, declarative statements that are from a textbook, and I don't know which chapter they're in, I don't know who wrote them, I don't know what they're referring to, and so without studying what it is that you're presenting to me, then I have to say that out of context I disagree.

Q. Okay. Unenhanced scans help determine whether a renal mass enhances after contrast material administration and facilitate distinction between hemorrhagic cysts and carcinomas; do you agree with that one?

MR. FOGARTY: Objection.

MR. POLING: Objection.

A. I'm going to disagree, and I'm going to specify that my disagreement relates primarily to the latter half of the declarative statement.

Q. The latter half being what, that they facilitate distinction between hemorrhagic cysts and carcinomas?

A. Correct.

Q. Okay. Renal cell carcinomas usually show enhancement following intravenous administration of contrast material, but the increase in attenuation value

is always less than that of surrounding normal parenchyma.

MR. POLING: Objection.

MR. FOGARTY: Objection.

Q. Agree or disagree with that?

MR. FOGARTY: Objection.

MR. POLING: Objection.

A. Disagree.

Q. Why?

A. Out of context.

MR. POLING: Note an objection to this entire line of questioning.

Q. Doctor, I'm just about finished here, but I do need to look at my notes.

I've seen the term "hyperdense" in describing a cyst. Are you familiar with that use of that term?

A. I've heard it, yes.

Q. Okay. Is that something that you use? Do you use that term, "hyperdense"?

A. Yes.

Q. What do you mean by it when you describe a cyst as hyperdense?

A. It's a lesion that proves to be pathologically a cyst, meaning no cancer or other problems, that gives you a higher than expected Hounsfield reading on CT.

Q. What about a "hyperdense mass"?

A. I'm not familiar with that term.

Q. Was this a hyperdense -- was Mr. Pietrangelo's cyst in his right kidney hyperdense at any point?

A. In my opinion, given a number of 24, I would say that that would probably -- most people would call that hyperdense.

Q. Okay.

A. The issue there was that he had had some contrast administered earlier in the day.

Q. Did you review the pathology reports of the pathologist that was done at University Hospitals?

A. I believe that I did.

Q. I think there were some femur biopsies; do you recall that?

A. I think there was just some material that was submitted when he had a fracture fixed, I'm not sure that they were actual biopsies.

(EXHIBIT MARKED FOR IDENTIFICATION.)

Q. This is No. 4 to your deposition, Doctor, it's a surgical pathology report, date of procedure 2/3/95.

A. Yes.

Q. And what does that report, Doctor?

A. On material that was taken from his femur at the time that he had his pathologic fracture fixed.

Q. Is this what you were referring to before that you'd had an opportunity to review?

A. Uh-huh.

Q. And go down the first page, I've stapled these together but they are different dates so we're going to have to identify each, but the Clinical Diagnosis and History on the first page of this report is: Question - metastatic renal cancer. Right?

A. Uh-huh.

MR. NORCHI: You have to answer audibly, Doctor.

A. Yes, Sorry.

Q. Second page, this is a cytopathology report, right?

A. Correct.

Q. From a fine needle aspiration of the bone.

A. Correct.

Q. And **I** guess here it wasn't -- it was an unsatisfactory specimen as far as the cytology?

A. The specimen did not contain any malignant cells.

Q. Okay. Again, Page 2 of that report we were just looking at, the Clinical History and Diagnosis is: Right femur mass - question - metastases - renal cell carcinoma. Correct?

A. I lost you now, I'm sorry.

Q. I was just looking at this Clinical History and Diagnosis that was up here. Just going page by page.

A. Yes. Okay.

Q. And then the next we have a surgical pathology report of a procedure 2/6/95. Did you review this report before?

A. I did, yes.

Q. Okay. And it indicates in here that -- it goes through some findings and indicates "That these findings strongly support a metastatic lesion arising from the kidney"; do you see that?

A. Yes.

Q. All right. Do you have any reason to doubt that the pathologist did an appropriate pathology study at University Hospital?

A. No.

Q. Do you have any reason to disagree with the statement that these findings strongly support a metastatic lesion arising from the kidney?

A. Only that they also support the possibility that there was a lung primary as well.

Q. That's what he's -- the pathologist, she is commenting upon, isn't she, the differential diagnosis being metastatic lesion from adenocarcinoma of lung or

metastatic lesion from the renal cell primary; right?

A. Right.

Q. And her statement is, after she describes the stain being negative for mucin, and the immunohistochemical studies she says, "These findings strongly support a metastatic lesion arising from the kidney."

A. In her opinion.

Q. Right. Well, do you have a basis to disagree with that opinion?

A. I do.

Q. You think that the pathologic studies support something else?

A. I think they're consistent with a possible lung primary as well.

Q. Wouldn't you expect to see mucin on a stain from a lung adenocarcinoma?

A. You can see virtually anything you want on histochemical stains on lung cancers or the absence of them, depending on their differentiation.

Q. All right. It indicates -- the next sentence is, "...clinical correlation is needed." What does that mean when a pathologist says "clinical correlation is needed"?

A. That there's additional information known to

the individuals who are caring for the patient that may be of some importance or help in terms of trying to sort out the problem.

Q. And that would apparently be referring to the treating physicians at University Hospitals.

A. Any treating physicians.

Q. And the treating physicians at University Hospitals, as we discussed, after this surgical pathology report indicated that they were dealing with a renal cell carcinoma, correct?

MR. FOGARTY: Objection.

A. Their opinion.

Q. Is renal cell carcinoma slow growing?

A. It can be.

Q. You looked at a '95 cat scan, correct, today, and you looked at the report before that, right?

A. Correct.

Q. Now, again, your report does not say anything about any interpretation of this '95 cat scan by you, does it?

A. It does not,

Q. Okay. And I guess that's because you weren't provided the -- well, I don't know. Strike that.

Is there something significant about this '95 cat scan that you intend to testify about?

MR. NORCHI: The scan or the report of the findings, or is there a distinction between the two?

MR. LANSDOWNE: Either-or, because neither of them is in your report. So --

MR. NORCHI: Sure, it is.

A. I reviewed the report and I think that the report and its contents certainly will be brought up at trial.

Q. And what is it that you find significant about the report?

A. May I trouble you for a copy of the report?

Q. Certainly. I think you have one right there, but...

MR. NORCHI: Here.

THE WITNESS: Okay.

MR. FOGARTY: Do you have it?

MR. NORCHI: I got it.

A. Yeah, the report talks about the identification of two separate masses. And that's a distinct difference from any of the previous scans going all the way back to '88, and certainly going up to the ultrasounds that Dr. Siminovitch obtained during his care, in which there was only one.

Q. So what's significant about that?

A. Well, it's a solid lesion. It could be a

metastasis from a lung cancer. Lung cancer is known to metastasize to the kidney.

Q. Could.

A. Could.

Q. You don't have an opinion that that's what it is though, do you?

A. No, I don't have an opinion that that is a lung cancer metastasis. No. It could be a solid neoplasm of some other type in the kidney that's not a renal cell cancer.

Q. Could be a renal cell cancer?

A. Could be a renal cell cancer.

Q. Could be that if the kidney was taken out in '88 or '91, that cancer never would have metastasized to his lung, bones and brain?

MR. NORCHI: Objection.

MR. FOGARTY: Objection.

MR. SIGMIER: Objection.

Q. Could be. Talking could be.

MR. POLING: Objection.

MR. NORCHI: He's asking about the possibilities, Doctor, which we've gone over before, so if you have an answer, please provide it.

A. What he describes is possible, yes.

Q. I take it you didn't see the whole study from

this date, the whole CT study from 2/9/95, correct?

A. What I saw is a single panel from that examination, and I would assume that that is not a complete collection of that study, yes.

Q. Okay. Did you read the impression of the radiologist in this radiology report?

A. Yes, I did.

MR. FOGARTY: Back a page.

MR. LANSDOWNE: Is that it there, or did I go past it? I'm sorry.

MR. NORCHI: Too fast.

THE WITNESS: Here.

MR. NORCHI: That's what he's talking about

Q. (By Mr. Lansdowne) His impression is of a complex mass in the right kidney with both solid and indeterminate cystic components, correct?

A. Correct.

Q. Does that -- that occurs sometimes, doesn't it, that there's a cyst that has both solid and cystic components?

A. Yes.

Q. And sometimes the --

MR. NORCHI: I'm sorry, I'm going to object. You said cyst or a mass with both solid in it --

MR. LANSDOWNE: I said a "complex mass."

MR. NORCHI: I thought you said "cyst," I'm sorry.

Q. Sometimes a solid component grows out of the cystic component?

A. That's possible, yes.

Q. I mean, you see that happen, corr ct? I mean, that does happen, I'm not saying in this case, I'm just saying in general that a solid component can grow out *of* the cystic component, correct?

A. I'm not sure I would agree with you.

Q. Why not?

A. Because I don't think that happens.

Q. Why don't you think that happens?

A. The pathogenesis of renal cystic disease is very different from the pathogenesis of renal cell carcinoma, and **I** don't think that cysts degenerate or differentiate into renal cell cancer.

Q. But can you have a tumor inside a cyst, correct?

A. You can have a cystic renal cell carcinoma, yes.

Q. Okay. And it could present as a complex mass.

A. It could present that way, yes.

Q. Just as it's described in impression No. *3* here

understand it's been a couple hours or so.

MR. NORCHI: A few.

MR. LANSDOWNE: A few. All right, a few.

MR. NORCHI: Stand corrected.

A. I would agree, I think we've covered the opinions that I have about this case. Yes.

Q. Okay. In terms of this '95 study, CT study, and I understand you haven't seen the whole thing, are you able to make a determination, I mean, do you agree with this impression here, No. 3, that the radiologist gives?

MR. FOGARTY: Objection.

MR. NORCHI: You mean separate and apart from the information before it?

MR. LANSDOWNE: I'm asking him if he agrees with his impression No. 3.

A. No, I don't entirely agree with that.

Q. Okay. What is it you disagree with?

A. Well, the impression states a complex mass in the right kidney with both solid and indeterminate cystic components as described above. However, if you go back to the body of the evaluation when the radiologist describes this, Dr. Lipuma says the right kidney is enlarged and demonstrates at least two separate masses.

And I don't think that that is emphasized nor is it even pointed out in the section entitled Impressions, so that's where I disagree with that impression.

I also have a -- I also have a disagreement with his interpretation that the solid mass, solid portion is most compatible with renal cell carcinoma.

Q. Okay. Why do you disagree with that?

A. Because it could be compatible with a lot of other things as well.

Q. Okay. I mean, it could be compatible with a number of other things, but he says it's most compatible with --

A. That's his opinion, and I disagree with him.

Q. Okay. So I guess you're saying with respect to the report that -- well, let me ask this: You looked at the film yourself.

A. Yes, I did. I looked at a portion of the CT.

Q. A portion of the film.

A. Yes.

Q. Are you able on that portion of the film to -- first of all, I guess you wouldn't want to make a full -- an impression of a CT scan study without the whole study, would you?

A. I would agree with that.

Q. All right. And obviously, Dr. Lipuma, you believe, would want the whole study available to him, don't you?

A. I would imagine he would.

Q. All right, And so that may explain why his impression in No. 3 -- which as we discussed is the interpretation by the radiologist, correct?

MR. FOGARTY: Objection.

Q. Correct?

A. Correct.

Q. Him having those other films may explain why he's concluded in this impression that it's a complex mass whereas in the body he referenced two separate masses, correct?

MR. FOGARTY: Objection.

MR. POLING: Objection.

A. I don't think so.

Q. You don't think so, but you really don't have any basis to dispute that.

MR. FOGARTY: Objection.

MR. POLING: Objection.

A. I think I do.

Q. What might that be?

MR. FOGARTY: Asked and answered.

A. He dictated the report and saw two separate

masses, and when he summarized, he just failed to complete his evaluation. Happens 11 the time.

Q. Well, he doesn't fail to, he noted that it's a complex mass with two separate components.

MR. FOGARTY: Objection. Objection. Objection. Objection.

A. No.

MR. FOGARTY: Asked and answered.

A. We're quibbling over words here I suppose, but he talks about a complex mass. A complex mass, singular.

Q. Right. With both solid and indeterminate cystic components, correct?

A. And that's very different from what I saw --

Q. Okay.

A. -- and it's also different from what he said in the body of his manuscript, and I think it has importance and bearing in this particular review.

Q. Okay. Well, assume it is renal cell carcinoma, okay? You're not going to offer any opinion that some renal cell carcinoma grew up in this kidney next to this cyst, are you?

MR. FOGARTY: Objection.

A. It seems to me we've already established in prior testimony that my opinion is that there was no

cancer present in '91 and '92; is that not correct?

Q. That's what you said.

A. ***So*** if I'm going to have to accept that there's a cancer there now, yes, I'm going to argue that there was no cancer there then, and that in the interval between the last examination and this one that he developed a cancer in that kidney. Yes, I will argue that.

Q. Okay. And it's --

A. Given the hypothetical that you're forcing me to deal with.

Q. Right. Which you don't accept anyway.

A. Which I don't accept anyway.

Q. Yeah. And did you see calcification in the '95 film?

A. I believe the film that he gave me was the postcontrast study.

Do we have that here?

MR. NORCHI: Do you want him to look at it?

Q. Yes, I would like you to look at it.

A. I'm pretty sure it was the postcontrast image and so I think that --

MR. FOGARTY: Here it is. It's one of these two.

A. Okay. This is the scan from 9 February '95.

Q. Is that the one you looked at?

A. This is -- yes, this is what I looked at, or if it isn't the one that I looked at, it's certainly the copies of the same thing.

MR. NORCHI: It's the one he looked at before the deposition.

Q. What's it marked as? Is it marked?

A. No, it's just --

Q. Okay, we know what it is.

A. Although there is no notation here on this particular set of images, without question this is a postcontrast study, and so assessment of the presence or absence of calcification really can't be made.

Q. Do you -- I mean, you say assessment can't be made. You don't see any, is that what you're saying?

A. I don't see any, but we already, I think, in testimony established and I agreed that contrast as well as slice interval can contribute to a false negative on calcifications.

MR. LANSDOWNE: Okay. Doctor, I don't have any other questions for you, but these other gentlemen may.

MR. SIGMIER: No questions.

MR. POLING: No questions.

MR. FOGARTY: No questions.

MR. LANSDOWNE: I guess not.

MR. NORCHI: Thank you. No questions. We're done.

Doctor, you have the right to review the transcript --

THE WITNESS: I will review it, okay.

There you go. Thank you.

(Signature not waived.)

(The deposition concluded at 6:20 p.m.)

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State of Ohio
SS:
County of Franklin

I, Robert R. Bahnson, M.D., do hereby certify that I have read the foregoing transcript of my deposition given on Monday, October 4, 1999; that together with the correction page attached hereto noting changes in form or substance, if any, it is true and correct.

_____
Robert R. Bahnson, M.D.

I do hereby certify that the foregoing transcript of the deposition of Robert R. Bahnson, M.D. was submitted to the witness for reading and signing; that after he had stated to the undersigned Notary Public that he had read and examined his deposition, he signed the same in my presence on the _____ day of _____ , 1999.

_____
Notary Public

My commission expires _____, _____.

- - -

CERTIFICATE

State of Ohio
SS:
County of Franklin :

I, Maria DiPaolo Jones, Notary Public in and for the State of Ohio, duly commissioned and qualified, certify that the within named Robert R. Bahnson, M.D. was by me duly sworn to testify to the whole truth in the cause aforesaid; that the testimony was taken down by me in stenotypy in the presence of said witness, afterwards transcribed upon a computer; that the foregoing is a true and correct transcript of the testimony given by said witness taken at the time and place in the foregoing caption specified and completed without adjournment.

I certify that I am not a relative, employee, or attorney of any of the parties hereto, or of any attorney or counsel employed by the parties, or financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Columbus, Ohio, on this 7th day of October, 1999

Maria DiPaolo Jones

Maria DiPaolo Jones, Registered Diplomate Reporter, CRR and Notary 'Public in and for the State of Ohio.

My commission expires June 19, 2001.
(Pad 829)